GUY'S

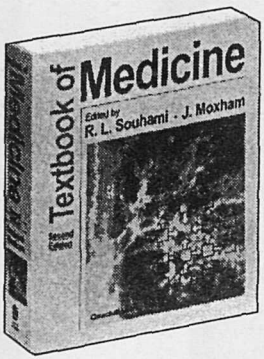
HOSPITAL GAZETTE

UMDS Guy's
23 FEB 1995
Wills Library

February 1995

- Sarah Stolz Lecture
- The Downfall of Dimpley
- Diwali Show

"Outstanding"



Textbook of Medicine

Second Edition

Edited by **R. L. Souhami** and **J. Moxham**

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Guy's Gazette

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Passim

With time marching on, the consultation period over the future of Guy's will soon be at its conclusion. The issues in the argument for maintaining services at Guy's are clear and the evidence is there to back it up. You don't have to deny a person water long before he succumbs; the analogy with a hospital and the closure of its A&E department can be seen. We need to keep fighting. The recent news of the shortage of ITU beds in London and the tragic death of a patient due to a bed not being found in time; only goes further to highlight the desperate situation London faces with regards to its health care provision.

Many have felt that the situation has deteriorated to such an extent that they have taken the drastic step of resigning. The strain of certain reforms in the NHS takes its toll not only on patients but also on the healthcare profession as well.

The freshers week has been over for some months now and students are in a rather better position to reflect on the events of their previous indulgences. Freshers week is an introduction into student life and most people are aware of the old cliché of medical students and their time honoured relationship to alcohol. The events of the last freshers week, in particular the hospitalisation of several students suffering from the ill-effects of too much cheap ale may leave them with a sobering thought, if you excuse the pun. In all seriousness, this did mar the event. Doctors' lives can at times be extremely stressful, resulting in high rates of depression, suicide and alcoholism. The issue is not whether one should drink at all, rather an issue of sensible drinking and knowing one's own limits.

The organisers of the Freshers week definitely undertook a huge task and a vote of thanks must go to them. There is however, a large section of people who do not see the bar as the focus of all social events on campus. Perhaps some sensitivity on the part of future organisers would not go amiss. Guy's itself looks to be undergoing a certain amount of renovation, with the re-erected memorial in front of Hunts House and maze of scaffolding with has seemed to descend on the Medical School and the library. The Harris Lecture theatre has also had a face-lift. Perhaps these are hopeful signs for the future of Guy's.

23 FEB 1995

Rodney Long

Dear Sir,

The address of the Rev. Malcolm Johnson at Rodney Long's funeral (October Gazette) prompts me belatedly, to write as one of his many Guy's friends and, I hope on their behalf, Rodney was a delightful and amusing, albeit rather shy, person. He was a founder member of the Guy's Theatre Club with a fine speaking voice and his Rupert Cadell in Patrick Hamilton's 'Rope' (Physiology Theatre, 1945) was especially memorable. He was extremely elegant in appearance but his colour blindness, on occasions, was responsible for an unfortunate clash of colours.

He loved laughter and humour and was particularly fond of the late Arthur Marshall's school girl stories which he would quote with infectious enthusiasm. Songs by Bobby Howes (preferably played at the piano by Michael Hall) and the music and lyrics of Ivor Novello delighted him and he would relate with pride the occasion he was able to thank personally Noel Coward for all the enjoyment he had given. The Master apparently said 'How terribly kind'!

Sadly he developed bad depression as well as rheumatoid arthritis. Regretfully, during his latter years he distanced himself completely, from his old friends and his company at reunions was much missed.

However there are a lot of us who will always remember him with great affection and associated with much laughter and happy times.

Yours Faithfully,

Dr D H Forsdick

Supply and Demand

Dear Sir,

I would like to relate an experience I had whilst doing my GP attachment today (24.1.95).

A patient had had to be transferred from the A&E department from a famous hospital in Waterloo to a local private hospital due to a lack of beds. The patient, a young schizophrenic, had absconded from the private hospital and could not be found; this is over 24 hours later. We rolled our eyes and rang up his mother to calm her down and to sort out the mess.

Yours Faithfully,

Bav Shergill

Top Doctor Resigns

Dr Jeremy Lee-Potter, the former BMA Chairman, Guy's graduate and Consultant Haematologist in Poole, has resigned from the National Health Service over the proposed introduction of locally determined pay for consultants.

Dr Lee-Potter said that the Government's dogmatic insistence on imposing market principles within the NHS had worried him, but the latest proposal, for local pay, would spell the end of the NHS as a national service.

'Commercially successful hospitals would be able to pay the highest rates with the consequence that other hospitals would find it difficult to recruit and would suffer shortages of consultants in some specialities,' he said.

'That would return us straight to the days before the NHS when centres of excellence attracted the best staff and hospitals elsewhere could not meet the same standard.'

He said the glory of the NHS was that it offered patients in all parts of the country equal access to well-qualified consultants.

Dr Lee-Potter's views were not shared by Mr Roy Lilley, chairman of the Homewood NHS Trust, who said that the team approach, not a consultant dominated service, was the way forward in modern health care.

Copy for Gazette

Articles for inclusion in the Gazette should be supplied double spaced, and preferably word-processed or typed. If handwritten, names in particular should be written legibly. If contributions are prepared on a word processor, it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format or Wordperfect 5.1 - or if in any doubt full details about compatibility of different files can be obtained from the Gazette office.

All feature articles should be approximately 1500 to 2500 words in length. Photographs and disks will be returned as soon as possible if requested. Authors are asked to supply a contact phone number in case of any queries that may arise.

Classified ads will be charged at £5 for 35 words and 15p per word thereafter. Changes of address will only be published if requested. There is no charge for this service, nor for annoucements of births, deaths and marriages.

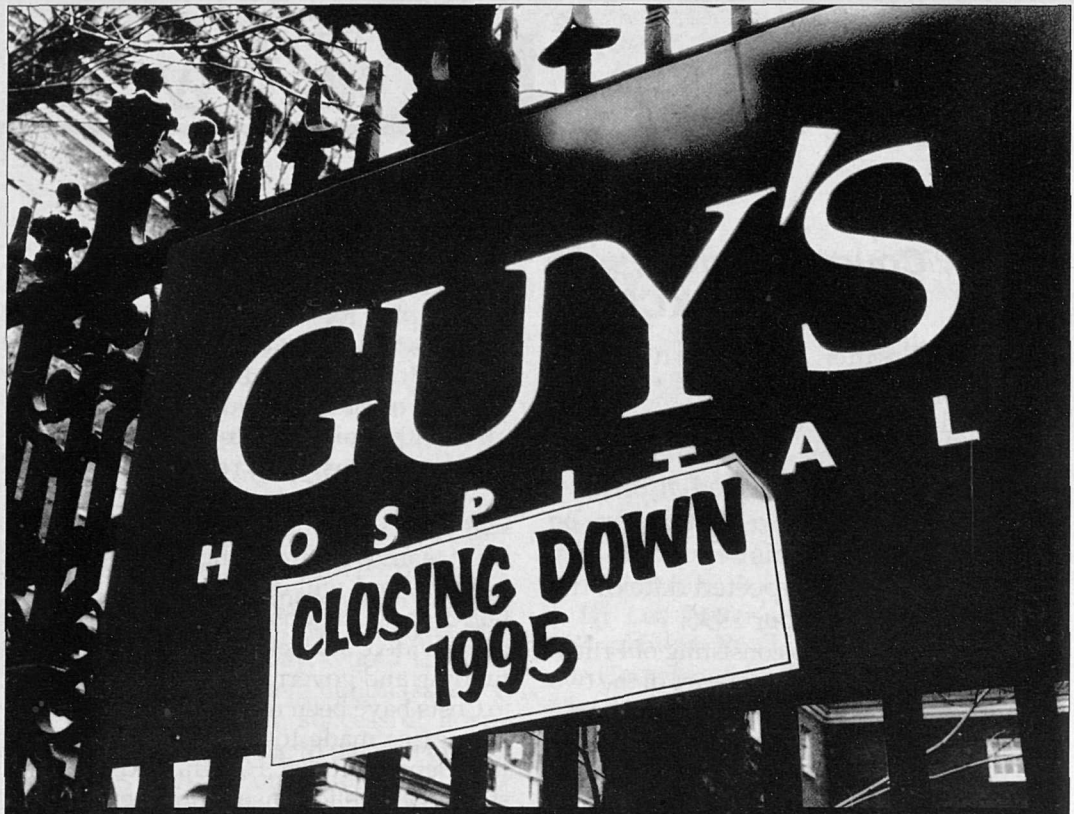
Council approves merger with KCL

The Council of Governors has agreed to the merger of UMDS and King's College London. A Parliamentary Bill enabling the merger was submitted at the end of last month, so that it can be considered in this session of Parliament. The expected date of the merger is October 1996.

A small group consisting of Principals and School Secretaries of the two institutions spent 48 hours in intense negotiations earlier this month, from which they emerged in agreement on all of the major issues. 'In any marriage one must make compromises,' said Cyril Chantler. 'We believe that we have reached an agreement that addresses the concerns of both colleges, and sets the stage for a successful merger'.

Even after passage, the Bill will only become law provided that certain financial and planning issues are met. The group has drawn up an outline plan for the resourcing, personnel issues and management of the project. This includes forming a number of project groups who will meet with senior staff to consider all functions, cost centres, relevant schools and subjects. These groups will ensure that the project management team is aware of the matters of concern, and will develop more detailed specifications of what should be provided, subject to constraints of funding and governance.

Costs have been requested in business cases made to the HEFCE and the Department of Health, and the statutory public consultation period on the health service changes has begun. The Secretary of State for Health is expected to make her final decision on the plan before the Easter recess of Parliament.



It could be the death of you.

The planned run down of Guy's hospital, or even a severe reduction of its vital services, must be regarded as a matter of life or death for many thousands of people.

Yet government plans to be finalised early this year could mean the effective end of Guy's as an Acute General Hospital.

To begin with, Guy's Accident and Emergency Unit – the very heart of an Acute General Hospital – would be closed down. This means that all of the acute beds would have to go along with most of the specialist, life saving services.

All that would then remain would be a greatly diminished hospital catering for some non emergency cases and some out patients.

But then there could surely be worse to come.

As history shows only too well, 'current plans' usually turn out to be just the thin edge of a very thick wedge.

Having reduced Guy's to a shadow of its former self, government could then claim it was no longer 'cost effective' and close down the rest of its services altogether.

Curiously, in recent times, Prime Minister John Major described Guy's as "... the flagship of the National Health Service..." Now, the government seems ready to torpedo it.

If you care about the health and well being of yourself, your family and the nation as a whole, please help us save Guy's from imminent run down and eventual closure. Write to your MP, the Secretary of State for Health Mrs. Virginia Bottomley and the Prime Minister at The House of Commons, London SW1A 0AA.

HELP SAVE GUY'S

Add your support to the campaign already backed by nearly one million people.

Guy's is one of the world's greatest and most respected hospitals saving lives every day. The people of Britain cannot afford to see it destroyed. Please do all you can to support our campaign.

I fully support the campaign to save Guy's hospital.

Name _____

Address _____

_____

_____ Postcode _____

☐ I wish to donate £..... to the Save Guy's Hospital Campaign.

☐ I would like you to send me more information.

TICK BOXES. Please make cheques payable to

'Save Guy's Hospital Campaign'

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Campaign Office Telephone 071-357 9260

Save Guy's Campaign

Campaign Update

Our first Campaign Update was issued in September. There has been some slippage in the original timetable, but events are likely now to gather speed, so we shall be keeping you informed by more frequent Updates in future.

The Campaign is very much alive and kicking, and it has done some excellent work. There could hardly be a better moment to attack the present Government, and to force it to modify its perverse and ill-considered proposal. The Evening Standard has just reported that a new policy of the DOH will permit financial arguments to be overthrown when deciding the future of hospitals held in high esteem by the public. This is very exciting, and we shall be pursuing this argument with energy.

Statutory Consultation: The SGC forced an undertaking from the SOS that her proposals would be subjected to formal consultation. The local purchasing authority, in our case the Lambeth, Southwark and Lewisham Health Commission (LSLHC), is therefore consulting publicly for 3 months. This process started on 18th November and will finish on 18th February.

LSLHC have issued a consultation document called 'Looking to the Future' in which they propose closing the A&E Department at Guy's, concentrating out-patient services at Guy's, and moving 'most' in-patient services to St Thomas' with the exception of an elective surgical unit. This is the Trust Board's Modified Option 5c outlined in our first Update. The Campaign believes this is not clinically viable, financially wasteful, and it is opposed by the public.

We have been assured by the LSLHC that this time there are no foregone conclusions and that the consultation and determination to reach the best conclusion are genuine. We can presume therefore that the recommendation of LSLHC will be sent to the government by about the end of February, with a decision expected before the end of the financial year.

SGC Proposals: The proposals of the Campaign have now been published and they are as outlined in the last Campaign Update. In brief, they involve the retention of the A&E at Guy's, together with specialist and some general beds. Together with the SGC proposals, the KPMG report, which the Cam-

paign commissioned to look at alternative solutions has been published as a working paper.

We believe our proposals are the only properly costed alternative to the Trust's unacceptable proposals, and we are confident that they would deliver better value for money, and involve much less risk of capital running out, and much less disruption of services while the changes were being worked through. The SGC will be presenting its proposals to the LSLHC.

Responses to the Consultation Document: The consultation document has been widely distributed and invites responses. A copy of the summary can be obtained by telephoning 0171 716 7000. Although the SGC has written a detailed critique of the proposals, anyone should feel free to respond formally. Because the constituent groups within the SGC may wish to stress different things there will be a number of responses from within the SGC, though of course our counter proposals are presented by the SGC as a whole. Individuals or groups are encouraged to send a copy to the SGC office. The address for responses is LSLHC, PO Box 4679, 1 Lower Marsh, London SE1 7XJ.

Petition: The petition to Parliament has now reached 970,000 signatures - on target for one million, so long as we don't let up on our efforts. Please keep the forms coming. We plan to present them to Parliament in early February.

Fundraising: So far the Campaign has raised about £160,000 largely due to the extraordinary energy of our Treasurer Michael Gleeson, though numerous others have given of their time and effort. Two recent fundraising events were very successful: a concert in Southwark Cathedral, and a 'Keep Guy's Alive Dinner' at the Hilton Hotel.

On the 27 December 1994 there was a collection at Millwall Football Stadium when Millwall played Watford. An 'Evening of Virtual Reality and Other Excitements' is planned at Hamleys early this year. This will be further publicised but please do ring the Campaign Office (0171-357-9620) if you want more information.

To show that their money is where their mouth is, a recent appeal to Guy's Consultants produced £16,000.

Publicity: We are very conscious of the potential of PR and advertising, but it is very expensive. We are very fortunate to have obtained the help of a senior in that world at no cost, and are planning an energetic and hard hitting campaign to start in the New Year. We are very conscious that most of the public do not even know that Guy's is threatened.

A truly effective campaign will be very expensive, so please be generous with your support, either money or possibly the name of someone who might be prepared to sponsor a whole page ad in the Evening Standard. It is vital that we run an effective conscious-raising campaign.

International Support: Many colleagues abroad, most of them very distinguished figures, have written to support us, expressing incredulity at the government's proposals. These are to be presented to the Prime Minister by one of our co-chairman Roger Sims MP.

Images of Guy's: In association with New City Gallery, the Campaign is offering 2 new watercolours by Terry McKivragen (one of the park and one of the main gates), and a coloured print from the graphic Magazine of 1896. These are available framed or unframed and cost about £60 framed of £40 unframed. Those interested should get in touch with the Campaign Office, PO Box 4016, London SE1 9TG. 25% of the cost is a contribution to the Campaign.

Sarah Stolz Lecture

The post-traumatic responses in children and adolescents - victims and witnesses of war in former Yugoslavia

The Sarah Stolz Annual Lecture was delivered on November 14, 1994 at Guy's Hospital by Veronika Ispanovic-Radojkovic, MD, PhD, Professor of Child and Adolescent Psychiatry, Institute for Mental Health, Belgrade.

I feel highly honoured by the invitation to give the Sarah Stolz Lecture established 30 years ago to the memory of one of many Jewish mothers - victims of Nazi persecution during World War II.

At the same time, I am deeply sad since I ought to talk about suffering of children in the war that started again, after 50 years, in my now former country, Yugoslavia.

Children in war are always and everywhere those who suffer the most.

But, let me remind you that the only concentration camps for children in World War II were located at the territory of Yugoslavia. In former Independent State of Croatia, in Jastrebarsko, near Krizevac and in Sisak. These concentration camps were formed in 1942 as a part of the system of Jasenovac concentration camps set up in the summer of 1941 and in which, by April 1945, about 750,000 people, mostly Serbs as well as Jews and Gypsies of both sexes and all ages had perished. Only from Potkozarje (the region around mountain Kozara) about 24,000 children of Serbian nationality were taken to Jastrebarsko and Sisak, concentration camps for children.

> ***'Children in war are always and everywhere those who suffer the most.'***

Why do I talk about this? Because I think that the events of World War II as well as the events of more remote past deeply influenced the development of 'inner psychological reality' of all the people who live in the Balkans, regardless of whether they were 'victims' or 'persecutors' in the past. Let me quote Ivo Andric, our Nobel Prize winner in literature: 'This people has suffered too

much unrest, violence and injustice and is too much accustomed either to bearing them with perfidious grumbling or to rebelling against them, depending on times or circumstances ... Sometimes you ask yourself whether the spirit of most Balkan nations is not poisoned for good and whether, perhaps, they will ever again be able to do anything else but to suffer violence or to commit violence.' These facts and that atmosphere, mediated consciously and unconsciously by their parents, have a great impact on the 'inner psychological reality' of all the children living now in Yugoslavia.

Milica, a twelve-year-old refugee from Croatia, now living in Serbia says: 'A long gone and terrible history repeats itself. The terrible and sad stories of our grandmothers have become reality. Why? Why?'

A 15 year-old boy from Karlovac, Croatia, now a refugee in Serbia, writes: 'I do not believe in God, but I wonder where the way out is, for this happened to both my grandfather and my father.'

I will talk about children who live in present, new Yugoslavia, Serbia and Montenegro - for this is the part of former Yugoslavia where I live and work.

However, I deeply feel and know that sufferings, concerns, feelings and thoughts of children in the entire former Yugoslavia are similar. Contacts with my colleagues, child mental health professionals from Sarajevo, Tuzla, Mostar, Rijeka, Zagreb, whom I had the privilege to meet in the past two years, at the meetings organized or supported by the UNICEF, UNHCR, WHO or other organizations, convinced me that my assumptions were true.

'Children in this war were too often terrified victims or helpless, silent witnesses of human madness.'

In this war, all children in ex Yugoslavia experienced the darkest side of human nature. They witnessed killings, torture, setting fires, revenges - horrors that even we adults consider the past and dark side of history that would never happen again.

In this war, many children experienced their dear and near ones, friends, schoolmates or even relatives as dangerous, threatening figures. The image of the world which had just started to emerge more clearly in their consciousness, darkened all of a sudden or became distorted, incomprehensible or unrecognisable. Their fathers and mothers who had been there before to protect, help and understand them, were now confused and frightened themselves, or were somewhere far away. Children in this war were too often terrified victims or helpless, silent witnesses of human madness.

Centuries-long human experience, that has also been confirmed by contemporary science, indicates that traumas experienced during childhood and youth leave permanent traces in the development of an individual. The consequences of war traumas are much bigger and far-reaching than the consequences of peacetime, most often isolated traumatic events and even wide-scale natural disasters as earthquakes, floods, etc. In the war, children are not only exposed to single traumas, but to various, repeated traumas during an extended period of time. In the war, the concept of traumatic process is more relevant than the concept of a single, even major traumatic event. Furthermore, the family, and the wider community, which provide protection and safety to the child in peacetime, are themselves affected by the war, sometimes even completely destroyed and incapable of functioning properly.

'...the family, and the wider community, which provide protection and safety to the child in peacetime, are themselves affected by the war, sometimes even completely destroyed and incapable of functioning properly.'

All these factors contribute to a more serious prognosis and outcome of the experienced war traumas than in the case of other types of traumas that children may be exposed to during their childhood.

Exposure to traumatic event with intensity and nature exceeding common human experiences, causes reactions in all exposed children. Developmental maturity, experiential growth, individual vulnerability and resistance, may alleviate the reaction to severe trauma - but cannot eliminate it.

Let us now try to explore, with less emotions, the impact of this war on children in Yugoslavia. Without doubt, this task would be much easier for you than me, the witness of the whole tragic situation.

Already in 1991, many children were forced to flee from the war in Croatia and leave their homes, with or often without their parents, and to find shelter in Serbia and Bosnia and Herzegovina. At the end of 1991 about 180,000 refugees, mostly from Croatia, were registered in Serbia and almost one half of them were children and young people. By spreading of armed conflicts to Bosnia and Herzegovina, many of those who found shelter there were again in the centre of war operations, for the second time in less than a year. New pain and sufferings were added to those still unhealed wounds of the previously experienced shock, fear and pain.

The escalation and intensification of armed conflict in Bosnia and Herzegovina in 1992/93 brought about more and more serious problems: an increasing number of refugees which amounted to nearly 600,000 by the end of 1993 and also more wounded and more casualties. Almost one half of them (249,000) were children below the age of 18. Among them 102,000 pre-school children were registered, including 10,000 babies born in exile and 17,000 children in the first year of life as well as 97,000 (16.6%) school children (7-14 years) and 51,000 (8.8%) aged 15-18.

The child mental health experts of the institute for Mental Health in Belgrade carried out research in 1992 to get a better understanding of the psychosocial reactions and disorders of children and young refugees and their relation to factors which are mediating or which might alleviate the impact of war events on children.

The results of the research were expected to contribute to planning and applying more adequate interventions as well as to a more successful organization of mental health services.

The research design and results will be summarized briefly.

Sample: The total sample (N=776) consisted of 593 child refugees (target group) from Croatia and Bosnia and Herzegovina and 183 local children (comparison group). The groups were matched by age (3 to 18 years), sex and basic socioeconomic features.

The refugee group included all the children (245) accommodated in the collective centre 'Cardak' (45 km from Belgrade, a former children's summer camp) and 348 children accommodated in host families in and around Belgrade (each fifth child from a Red Cross register was sampled).

Method: A special semi-standardized questionnaire has been designed. The data on sociodemographic structure, family relations, the child's development and actual psychological symptoms and disorders and on traumas related to war and exile were gathered during a personal interview of the child and accompanying adults (if available). Interviews have been conducted by 10 highly-skilled child mental health professionals (child psychiatrists, child psychologists). The questionnaire was supplemented by applying detailed instructions and a glossary of psychological/psychiatric terms based on DSM-III R definitions. The data were analyzed by using chi-square test, multiple regression, and hierarchical loglinear analysis.

Results: According to our research, before going into exile, more than a half of the children (55.7%) had been exposed to severe traumatic stresses. 41.3% of children experienced direct life threat (exposure to shooting, shelling, threats by armed people), 14.4% witnessed the killing or wounding of parents, other family members or familiar persons. Other children can be included in

the category of those who experienced 'milder' traumas, eg, before going to exile in Serbia, they had spent a month or more in shelters, cellars, on the nearby hills - without regular meals, living in fear and uncertainty.

Symptoms of psychological suffering have been present in 62.4% of refugee children, and only in 13.7% of the local children, which is a significant difference (chi square = 130.95; df = 1, $p<0.001$).

The DSM-III R criteria of mental/behavioural disorders were fulfilled in 35.2% of refugee children, which is again significantly different from the local children (chi square=40.07; df=1, $p<0.001$).

Symptoms more frequently exhibited in refugee children in comparison with the local children were: feeling of physical tension (27%), sadness and depression (26%), tearfulness (25%), anxiety and irritability (20%), withdrawal (17%), increased attachment (13%), fears (12%), terrifying dreams (9%), sleeping difficulties (8%), quarrelsome behaviour (9%), aggressiveness (8%).

The most common symptoms observed in pre-school children were separation anxiety, attachment disorder, the loss of newly acquired functions and regressive behaviour. School-age children more often manifested somatic disturbances (headaches, fatigue, stomach aches), poor school performance, associated by passive, inhibited or aggressive and demanding behaviour. Both types of behaviour increased the social isolation and alienation of the child. Fear of renewed trauma and guilt feeling due to experienced trauma were more often observed in this age group in comparison with pre-school children and adolescents.

'Adolescents often manifested autodestuctive or acting out behaviour...'

Adolescents often manifested autodestuctive or acting out behaviour, eg, rebellious behaviour and the inclination towards antisocial activities. Such behaviour presented a serious problem in the communication with the family, ie with the young person's environment. Detailed psychiatric exploration indicated that the most frequent basis for this behaviour was a prominent depression which was not recognized by the environment.

More than half of the refugee children (54.1%) had symptoms for over six months, one third (34.8%) between 1 and 6 months, and only 11% of children manifested these symptoms for less than a month.

There was a significant difference between children who were exposed to war stressors (N = 320) and the group of children who were exposed to moderate or mild stressors (N = 272) as regards the frequency of the symptoms of psychological difficulties (67.5%: 56.4%) (chi square= 7.26, df=1, $p<0.01$),

and particularly the frequency of diagnoses made according to DSM-III R criteria (42.8%: 26.4%) (chi square = 16.73, df = 1, $p<0.001$). The increased number of stressors the children were exposed to caused the increase in the number of children with symptoms (chi square = 14.36, df = 3, $p< 0.01$).

In the war in former Yugoslavia, especially in Bosnia and Herzegovina, the exposure to multiple traumas in a period several months preceding the exile was a common phenomenon. Two thirds of exposed children experienced 1-2 traumatic events, one third 3-5, while 13 children were exposed to more than 5 traumatic events.

Many children who were exposed to multiple severe traumas reacted with psychotic symptoms or severe forms of PTSD and needed hospital treatment. From July 1991 to December 1993, 145 children and young refugees, 17 of them with psychotic clinical presentation, were treated at the Institute for Mental Health in Belgrade.

More recent reports in literature indicate that the exposure to mild or moderate stressors, eg indirect knowledge about traumatic event through media or even the anticipation of a threat to one's physical integrity, can lead to severe psychopathological consequences in extremely vulnerable persons. In the development of post-traumatic stress disorder, a subjective perception of trauma, ie the person's subjective feeling of a threat is as important as the severity of the stressor itself.

Our experience is in favour of the view that the reactions to disaster in children 'did not vary according to where they were or what they saw that day as much as according to what they felt' (Scwartz, 1991). Therefore, children should always be asked about their feelings and not only about the catastrophic event itself.

These facts are of important practical significance since they indicate that our preventive and therapeutic measures should be directed not only towards children who experienced severe traumas but also to those who overreacted due to their increased individual vulnerability.

Searching for the factors which might increase or possibly mitigate the effects of war trauma in children, we found that the family and social support is of special importance.

War inevitably affects family structure weakening its natural protective and mediating function between child and world and sometimes even destroying it. Forced separation, temporary absence or a permanent loss of family members, the loss of property, impoverishment, etc are common and even unavoidable war phenomena.

Among the multiple adversities of war, a special place belongs to the separation of the child from his family, either due to evacuation for safety

reasons or forced exile. Observations of the effects of children's separation from parents were often contradictory in the past. British experiences from the beginning of World War II, when due to bombardment children were evacuated massively from London, suggests that the evacuation itself inflicted more harm upon children than the air raids. Later studies proved that the effects of separation depend upon the circumstances of the separation, and especially upon the previous preparedness of children and parents. There is an agreement nowadays that emotional accessibility of the parents, their empathy and provision of a cognitive framework for the understanding of a traumatic event, makes it easier for their children to integrate the traumatic event. Parents' minimization or denial of the threat increases the anxiety and mistrust in the child, while their unalarmed reaction soothes the child.

In our sample, a significantly greater number of children with symptoms of psychological difficulties, in comparison with children without these difficulties, experienced their parents' behaviour as overreacting (exaggerated fear, anger-rage, crying, sadness, quarrelling) (25.4%: 3.1%) (chi square = 47.52, df = 1, $p<0.0001$). We are aware that the given answers are a reflection of child's perception of parental behaviour, reconstructed several months after the event. We were not able to carry out more objective assessments of parental behaviour in traumatic situations, and therefore we asked the children to describe and assess the behaviour of their parents or other adults who were there with them. Considering the fact that in our research parental/adult reaction proved to be the best predictor of the number of symptoms in child refugees, special attention is to be paid to this result. Further research in this area would be useful to increase our understanding of the ways of the impact of trauma on children can be lessened or alleviated.

'Many refugee mothers with young children...manifested depressive behaviour.'

In our situation, many refugee mothers with young children, and especially those who lost their husbands, another child, or a close relative, manifested depressive behaviour. They were watching TV or listening to the radio for days expecting the news from their old home, or war zones. They were overwhelmed by sadness and hopelessness and often were not able to identify emotional needs of their children or react to them properly. They experienced intense dependence or regressive behaviour of their children in stressful situations as intolerable and reacted with frustration, anger or rejection of the child. For this reason, that category of mothers needed special attention in terms of providing social and emotional support.

Practical implication of these findings is that parents and family in war need support both during and after traumatic event in order to be able to perform their protective function and help the child to recover from trauma.

In addition to children who experienced severe trauma, special attention should be paid to children whose parents are insecure, terrified, and who overreact to a traumatic event or neglect the emotional or social needs of their children. Special attention should also be paid to the following groups of children: those whose fathers are absent, at the front or as prisoners of war, children whose fathers manifest psychopathological disturbances (PTSD, depression, alcoholism) after returning from the front. Special attention must also be paid to children who experienced death or injuries of their closest family members and reacted with the sense of guilt or self-punishment. We came across children who perceived the death of their father as deliberate desertion, revenge or punishment because of their previous 'evil' desires, feelings or thoughts about the dead parent. Pynoos and his collaborators (1985) are also warning that the sense of guilt in a child should always call our attention since those children bear a higher risk in terms of occurrence of difficult forms of post-traumatic stress disorders.

Children born into mixed marriages whose parents are in conflict or getting divorced due to national, religious or political reasons are also at risk. In former Yugoslavia there were 1,200,000 mixed marriages, ie, every seventh marriage was a mixed one, as well as every third marriage in the regions most affected by war.

Finally, unaccompanied children who are in exile, especially those in collective centres also require special attention. Therefore, the programme: Unaccompanied Children in Exile, being implemented in ex Yugoslavia by the British Save the Children Fund, is of the utmost importance.

In addition to the presence and emotional accessibility of the parents, solidarity of the community and a high level of support to traumatized persons can significantly alleviate the adverse effects of war experience.

The reception and care for refugees in Serbia, especially for refugee children, was characterized by a warm solidarity which is obvious from the fact that 94% of all the refugees found shelter in host families, with relatives, friends or other previously unknown but humane people ready to share all they had with those in need. Only 6% (about 26,000) of refugees were accommodated in collective centres.

The results of our research also confirmed the assumption that the support of a family, even not one's own, is significantly more favourable for activating the mechanism of recovery from the experienced trauma and encouraging a more healthy, creative personality potential, in comparison with the support

which can be provided in collective centres. There was a significantly greater number of children with symptoms of psychological difficulties among refugees in collective accommodation (70.8%) in comparison with refugees in host families (56.5%) (chi square = 11.43, df = 1, $p<0.001$).

The fact is also that the government supported this type of accommodation in host families with various subventions and exemptions for both host families and refugees. Unfortunately, the sudden worsening of the economic and social situation after the imposition of UN sanctions against Serbia and Montenegro, has lead many host families to the brink of poverty, scarcity, deprivation, unemployment, all of which has drastically worsened the conditions for providing help to refugees. I hope that the following data will illustrate the deleterious effects of the sanctions on the overall situation in the country, and especially on its most vulnerable population groups.

From 1990 to 1993, FR Yugoslavia registered the cumulative loss of over US$, 25 billion in its gross national product (GNP) in relation to 1989.

'Unemployment has rapidly increased, some 1 million former employees of the public sector are out of work'

Unemployment has rapidly increased, some 1 million former employees of the public sector are out of work (of the total 2.3 million employed) or have lost their jobs due to the UN sanctions and some 700,000 more have been on compulsory leave. All this triggered hyper inflation which reached about one million per cent (28% per day or 1.5% per hour) in December 1993. Living costs in December 1993 increased 283,900% in relation to the previous month.

The volume of the total production has been drastically reduced, the per capita GNP dropped from US$ 2.330 in 1991 to US$ 1.750 in 1992 and 1.320 in 1993.

In the last trimester of 1993, real monthly earnings averaged around US$ 12, while average pensions did not exceed US$ 8. Living standards of some 85% of all the population in FRY reached the point of mere subsistence, and currently about 50% of the population are classified as persons in need of social welfare.

These factors did not only considerably impede the provision of help and care of refugees, but also seriously endangered the mental health of the overall population of FR Yugoslavia (10.5 million). The most vulnerable population groups are most severely affected: children, pregnant women, mothers of young children, elderly people, disabled, sick; all those who are innocent victims of war and by no means responsible for it.

Fully aware of the threat of war, exile and social crisis, on the mental health of the population, the experts of the Institute for Mental Health in Belgrade started already in 1991 the activities in the field of prevention and alleviation of negative effects of war and exile on children and youths.

On this occasion, I will only briefly summarize the activities from 1991 until nowadays.

The training of professionals and others working with children was the highest priority:

1. Training of primary health care workers (PHCW) in prevention and management of psychosocial consequences of war and crisis in children, adolescents and their parents started in July 1991. In the period between September 1991 and June 1992, about forty one-day training seminars took place in regional centres of Serbia. About 3,000 health care workers and associates took part in the seminars (general practitioners, psychologists, social workers, school teachers, Red Cross workers, etc).

2. The Manual: Mental Health Care of Children, Young People and Parents in War and Post-war Circumstances, with the guidelines for work with children and parents in the situation of war and crisis has been published.

3. The Training Programme for paediatricians working in primary health care services in the regions with highest concentration of refugee children (Belgrade area, and north-west part of Serbia) took place in 1993 and was supported by UNICEF. About 120 paediatricians attended the three month-training.

4. Advanced Training of Child Development Counselling Services (CDCS) teams from 10 centres from the areas with high density of refugees (Belgrade, Subotica, Kraljevo, Cacak, Sombor, Uzice, Sabac, Nis, Leskovac) has been supported by WHO/EURO. The aim of the training has been to strengthen the efficiency of the CDCS network in preventing the impact of war-related stresses on high-risk groups of children.

5. Training of Specialized Teams of Child Mental Health Professionals (child psychiatrists and psychologists) in providing highly-specialized help to children with severe war-related disorders (PTSD, depression, anxiety disorders, severe behavioural disorders) is our actual priority and further international input would be most welcomed.

6. National Information and Training Centre on Disaster Psychiatry in Childhood has been established at the Institute for Mental Health. OXFAM, (one of the largest non-governmental charities in Great Britain), provided the centre with CD-ROM Medica Databases in Psychiatry and Neurosciences which is, at the moment, the only source of information for mental health professionals of Serbia and Montenegro. OXFAM recognised the importance

of regular, professional exchange and updated information in the new situation when we were not receiving any professional literature, journals, etc due to UN sanctions. Thanks to them we were also able to continue publishing our Journal Psychiatry Today, which was, after 25 years, for the first time interrupted by the lack of resources.

OXFAM also supported the psychosocial programme for adolescents who are a highly vulnerable but often overlooked group.

7. 'Let's Be Friendly' Clubs for Young People represent a Programme for promotion of psychosocial development of young refugees which has been first implemented in 9 Belgrade boarding schools (2,600 students of secondary schools including 600 refugees) and now is being extended to other regions in Serbia with high concentrations of adolescent refugees.

I would also like to say a few words about the importance of support of colleagues from abroad in situations of war, crisis and similar disasters. We in Yugoslavia badly needed such support. We needed recent scientific information and exchange of experiences on traumatized children, on refugees, on trauma interventions. Unfortunately, the imposition of the UN Security Council sanctions against Serbia and Montenegro in June 1992, placed us in almost complete isolation from the rest of the world. Co-operation has been cut off not only in economic, but also in scientific, cultural and even sports events. Not only the imports of medicine, spare parts and other sanitary material, of food and heating fuel, but also the professional and scientific exchange like subscriptions to medical journals, our membership in international associations, our attendance at international meetings, have been hindered. The UN Resolution 757 from 1992 in Paragraph C, for the first time since this organisation was founded, demanded that all country members suspend the scientific co-operation and exchange of scientists with FR Yugoslavia.

'More than anything - more than hatred and torture - more than pain, - do I fear the world's indifference.'

We secretly hoped that our colleagues from other parts of the world would raise their voice condemning the sanctions, just as they were condemning the war. Nothing, but a long silence. At that time, I myself felt deeply all the pain and truth of the Elie Wiesel's words: 'More than anything - more than hatred and torture - more than pain, - do I fear the world's indifference.'

At last, the world scientists, after almost two and a half years of silence, have aroused their voice against the punishment of their Yugoslav colleagues. At the Conference of the Association for Medical Education in Europe (AMEE)

recently ended in Athens (from 4-7th September), the Resolution was endorsed by which any kind of punishment of the scientists is being denounced. The first public support to Yugoslav colleagues, since 1992 when our country was excommunicated from the international community, has been worked out by the efforts of our Greek colleagues and especially by George Christodoulou, Professor of Psychiatry at Athens University, President of the Hellenic Psychiatric Association (Athens Branch) and President of the European Board of Psychiatry of the European Union.

The above mentioned Resolution adopted at the General Assembly of the Association for Medical Education in Europe (AMEE) states: 'The imposition of sanctions on any country should by no means include restrictions of any kind of medical scientific co-operation with other countries or suspension of interactions between scientists.

In cases where imposed sanctions or other restrictive measures are prohibiting scientific co-operation and exchange, we call for every effort to be made for with the withdrawal of sanctions which deprive people in these countries of those health benefits, and to cease the collective punishment of these people'.

250 scientists from 35 countries from all continents attended the Athens Conference.

But, long before this event, almost a year before, which was an eternity for us, a Man came and supported us, child mental health professionals, who from the first days of the war have endeavoured to protect children and to alleviate their sufferings. That was Tony Cox, a distinguished Professor of Child and Adolescent Psychiatry, and no doubt, a member of many committees, steering groups, editorial boards, but above all, a MAN (and a FRIEND).

His professional knowledge, his listening and observing skills and, above all, his empathy have been of immense value to us. On behalf of my colleagues and myself, I express our deepest gratitude him. (Thank you Tony, thank you indeed).

This support helped us restore the faith in solidarity and kindness of the Mankind. Without such experience we risk to become alienated, distrustful, to fear the world or become hostile towards it. However, experience of human solidarity is even more important for the children since only that can help them restore and develop the image of the world which they can trust and wish to live in. Restoring the child's faith in the world, which has been profoundly shaken by the terrors of war, is as important as provision of food, warm clothes and shelter.

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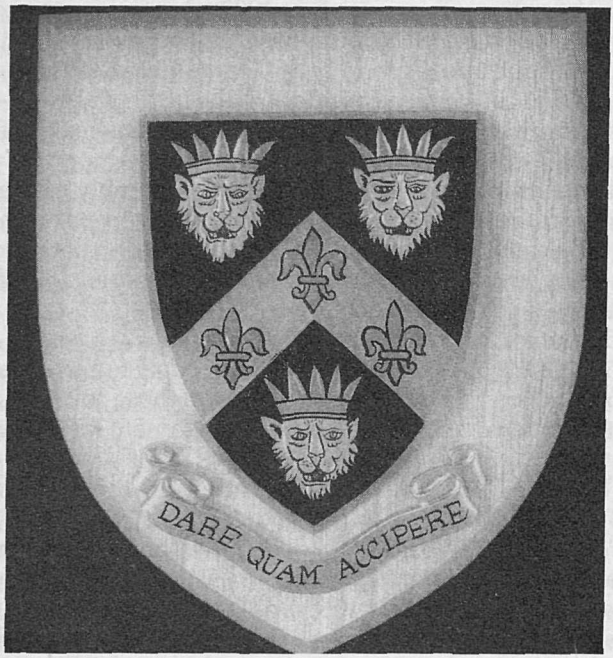

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Students at Guy's: The New Intake

Downfall of Dimpley; or, The Leisure Principle

Professor Phantom, Tutor for Admissions, puffed at his Castella, his mind wandering. He considered the 11-year sunspot cycle, and its relation to the incidence of student dropout--he must ask Angela to attempt a correlation.

'Please continue Mrs Black.'

'Well, I know you like to take a close interest in student affairs, and you are also Duncan's personal tutor, so I thought you ought to know.'

'But surely no-one has been dropped from the medical course for failing first-term statistics before?'

'There's always a first time, Frank, and he's failed the viva and re-sit too. I think this may be indicative of a wider problem.'

'In what way is that, Mrs Black?'

'Well, let me explain.'

The arrival of Duncan Dimpley at Guy's Hospital (well, actually, U.M.D.K. Bart's.Mary's.S.) to study medicine represented a sunny day in an otherwise eclipsed academic career, and he was rightly self-satisfied, for the moment. The eclipse would depend on one's perspective, however, and in other ways Duncan had, in the words of Bill and Ted (hail the Almighty), had a truly bodacious time. And now, he felt that this aspect of his life could be expanded in the freer environment of University life.

Duncan remained unfamiliar to most lecturers for at least the first half of his first Christmas term, and was seldom seen in Dissection sessions or tutorials. So it was with an almost gleeful enthusiasm that Dr Thatching welcomed 'Mr Dimpley, is it?' to his anatomy tutorial in the Dissecting Room Annexe. The tutorial began.

'Mr Dimpley,' Dr Thatching started, chuckling quietly to himself, 'could you refresh our memories as to the origin and course of the subclavian vein?'

'Could you repeat the question, please?'

Academic life did, indeed, have its rewards.

'Certainly. I was hoping you may provide some enlightenment regarding the subclavian vein. For instance, where is it located?'

Duncan lifted his left index finger and pointed, a little uncertainly, to his midriff. 'Well, that's thorax, isn't it?' he thought. Some of the other students laughed, then pretended to clear their throats. 'Nice one, Dunc,' one whispered.

Dr Thatching exhaled wistfully, and decided to approach the problem (a problem?) from first principles, without hopefully needing to refer to the alphabet.

'Let's try splitting up the word, shall we? What would that give us?'

'Sub and clavian,' replied Duncan.

'Good. Now, what does sub mean?'

'Beneath.'

'Excellent. And clavian?'

A long pause.

'What about clavicle?' proposed Dr Thatching.

'Yes, of course,' nodded Duncan wisely.

'Well, where is it?'

Again, Duncan's left index finger rose up awkwardly, and he wondered for a prolonged moment how such a thing could have evolved.

Dr Thatching got up from his stool.

'Let's have a look at the skeleton,' he sighed, and the tutorial continued.

Like the Hundred Year War, the tutorial eventually came to an end. After a quiet word from Dr Thatching concerning attendance, and how Duncan would do this, Duncan left, depressed but relieved, perhaps feeling for the first time some of the pressures of academic life. He considered briefly why he had gone to the tutorial in the first place, and concluded that this was a phase all students went through. He realised that some limitations would have to be set on his social life. Some.

Socially, Duncan hopped (at UMDS) and crawled (from pub to pub), and his attitude to life exacted a certain admiration from his peers. Moreover, despite his poor initial tutorial performance, and the occasional embarrassing appearance of his head around the entrance to a packed lecture theatre, he improved. Duncan was bright, after all (given his work density, he had had to be), and he developed a strategy for coping with tutorials and dissection sessions.

He found that these usually began with a series of relatively straightforward questions which most students knew, and yet were reluctant to answer. Thus, Duncan became skilled at monopolising this part of a tutorial, and quickly answered any later questions he happened to know. In this way,

relying on the democratic nature of tutors, he knew that he would probably not be targeted for more searching questions. Nevertheless, occasionally seemingly innocuous questions (which he termed leaders) defeated this tactic. For example, in one Pharmacology tutorial:

'Could anyone give me the name of a minor analgesic?'

'Acetyl salicylic acid, otherwise known as Aspirin.' (Suitably impressive).

'Very good, Duncan, and what else is Aspirin used for?'

Silence.

'Gout?'

Duncan suffered few casualties in this area, however, and towards the end of the first term was not too conspicuous in his ignorance, and was thus free to pursue his many leisure interests (ie drinking). So it was that, when revision began 2-3 weeks prior to the Christmas term exams, Duncan was admirably nonchalant. At the Bar, when asked revision questions by fellow students, Duncan countered by asking about some obscure point of interest, usually evoking a worried response of 'I haven't learnt that yet. Do we need to know it?', or, 'I can't remember, and I only learnt it yesterday.' In return, no-one asked Duncan 'obvious' questions, just as one would not ask Mendeleev the formula of salt.

Exam day beckoned. The only 'official' exam was Part IA or Statistics, so naturally Duncan did no revision except for this, which he did the night before the exam.

It was not enough. Duncan was as cool as ever in the examination hall, and his expression did not change even after seeing the questions. He was philosophical in that way. 'All I have to do,' he thought, 'is to show the examiners I am a competent statistician. They are not out to fail me.' So when the question asked for a chi-squared test of a set of data, Duncan discussed (in some detail--based on A-level Mathematics) the concept of a mean and standard deviation, and constructed a plausible looking table, without resorting to any actual calculations. His approach was similar for the other questions, which also sadly did not coincide with his revision.

Consequently, Duncan failed, being one of three to do so.

'Never mind,' he said to one of the trio as they drowned their sorrows at the Bar, 'the viva will be fair, and, hopefully, on a more general theme. We'll pass.'

It was not, but they did all pass (except Duncan).

Duncan only had one more chance--the re-sit exam half-way through the Christmas holidays, but, what with one thing and another, revision was left rather late, and he did it again (failed, that is). Duncan was somewhat distressed at this outcome, but not entirely distraught, as he had heard rumours

of what lay in store for medical graduates in their pre-registration year. Moreover, he had friends prospering quite comfortably thank you in the pharmaceutical industry...

So it was that Professor Phantom reluctantly, but inevitably, closed the curtains on Duncan's medical career. And just for failing statistics. He had tried to encourage Duncan each time he missed the mark, but the boy simply had not responded. It had never happened before.

POST-SCRIPT: Duncan is now a Biometrics Section Head at Procter & Gamble Ltd (look at your next Ariel soap-powder packet), earning £50,000 per year and working 37 hours per week, so put that in your pipe and smoke it junior doctors! Party on, Duncan.

John S Gilbody

The 1994 Diwali Show

A Taste of Eastern Entertainment

Following successes in recent years, this year's production of the UMDS International Society Diwali Show had somewhat distinguished shoes to fill. This mammoth task was taken up admirably by a record number of scholars, on one of the few occasions when dentists and medics actually unite! The pre-show hype, as always, left a mouth watering feeling in the buccal cavities of prospective attenders and cast alike. The show itself, having left its roots in the Harris lecture theatre for pastures fresher, was performed for the first time in the larger, more spacious surroundings of what was formerly the Greenwood Theatre. However, for all it's benefits, the Greenwood lacked the welcoming atmosphere that once filled the Harris (let's hope that this has not set a precedence for years to come).

'The eagerly awaited performance night had arrived and the 400 plus crowd were hungry for entertainment...'

The eagerly awaited performance night had arrived and the 400 plus crowd were hungry for entertainment in the form of laughter and good music! Little did they know it but the audience had let themselves in for a three hour long epic, composed of an array of comic sketches, a live band and yet again a 'fashion show' which for the most part was disappointing. The audience was graced with a modern rendition of Diwali from the mismatched duo who were delegated the task of controlling the evenings proceedings. In all fairness they played their roles well for most of the night, though one did feel that their efforts were becoming a little cumbersome towards the end.

'The atmosphere was starting to come alive...'

The atmosphere was starting to come alive, the crowd offering their thoughts in the form of heckling as the show progressed, although the crudity of some members was neither warranted nor was it appreciated. So on to the first act, the classical South-Indian dance of the Bharatnatyam eloquently

performed, adding a cultural theme to the show, which in retrospect was probably one of the more favourable acts of the evening. Next followed, what one can only assume to be the show piece of the production, UMDS' very own fairy tale...'Cinderani'. Although well performed and full of laughter, this comic sketch lacked a fluent theme and in some respects reflected the plot of Aladdin more than Cinderella. The roles of Cinderani, which one would have thought to have been a lead, and Prince Charming were disappointingly left lurking behind in the shadow created by the remainder of the cast, whose collective performances were rampantly forthcoming. The winners for me were the enigmatic 'Genie', played by, I believe, one of the few acting talents at UMDS; the two very ugly sisters and UMDS' very own answer to Manchester's 'Take-That'...Take Chaat! The cast provided wit and humour manifested in a collection of aptly chosen jokes and gesticulation. The rendition of 'Girls just wanna have fun' from the drag duo swept the audience into spontaneous laughter, with promise of an encore latter on. Although coming to a disappointing conclusion, the play in itself was a delight to watch and was well appreciated by the audience as a whole. Following the welcomed half-time interval, the audience were in anticipation of an equally fruitful second half. The spectacle that followed the interim however, fell well short of expectation and was received with great bitterness. The fashion show which dominated this half, was grossly indifferent to those of years gone by. With the exception of the 'wild-west' opening act, the remainder of the fashion show lacked originality in thought, co-ordination in movement and more significantly...tempo! It amazes me that the comments of previous years' fashion shows are never acknowledged and as a result this component of the evening always seems to mar the overall success.

'The rendition of 'Girls just wanna have fun' from the drag duo swept the audience into spontaneous laughter...'

However, the cast partially resolved themselves with an aptly chosen comedy sketch with which the majority of the crowd could relate to. The 'Consultants Ward Round' had more promise than was actually delivered but since the scene was a topical one, the cast forced a wave of laughter out of the crowd. What was disappointing for me was the fact that laughter was being directed at the accents of the cast as opposed to the punchlines of the script. Firstly, although very funny and certain to encourage laughter, this accentuation of Asian culture is potentially offensive to certain members of the audience (*I make reference here to the parents, who this year made a more significant presence*

than in years gone by). Secondly, this tone of voice shows no credit to those who have written the script.

It is difficult to make comment on the musical aspect of the evening, since the band and its vocalists were plagued with the recurrent nightmare of being drowned out by their own echoes. Technical faults aside, the band, which this year included a saxophonist, consisted of many new faces and a few from the dark past. The audience saw the re-emergence of a voice from Diwali past, in the form of a familiar Guy's houseman, though his melody fell a little short of melancholy. The female vocalists scaled (*no pun intended*) a spectrum ranging from inaudible to shattering, though I'm not suggesting that this is a reflection upon them but is probably more an indicator of the difficulties they were faced with. Overall it would be fair to say that the band, this year, did not have the same impact as in years gone by.

In summary, the show although disappointing in parts was lifted to heights of dignity by the more memorable first half and as a result the cast and organisers are warranted to deem this production a success, although at £8 for a ticket whether they can boast value-for-money is a separate issue.

Rikin Trivedi

Anaesthetics

Just what you've always wanted: an all new Handbook (to keep at hand) of Anaesthetics and Perioperative Care. This is Ponte & Greens opus when it comes to anaesthesia. As they correctly identify in the preface anaesthetics teaching is an important part of the medical curriculum as firstly it is a good opportunity for one to one teaching and two, anaesthetics represents all the best bits of pharmacology and physiology in action. You don't look convinced? Take it from me, even though I am a confirmed spod under a mountain of books and papers!

Anaesthetics is said to be the largest medical specialty; this means there is a great deal to be written about the business - even if restricted roughly to an undergraduate level. Not only does the anaesthetist deal with the obvious tube in the larynx, gas in the patient, patient in the operating theatre with surgeon ready to begin situation but also other aspects such as pain management (big business now in leafy suburbs), management of shock and serious trauma and intensive care medicine. This book pretty well covers the lot with a quick multiguess thrown in if you're feeling confident.

This is a useful guide to accompany a lecture course and in your pyjamas, practical work in theatre or on ITU. The book is well presented with diagrams detailing equipment, illustrating the relevant physiology and clarifying the relevant anatomy. Reading this book will aid understanding of many stinkers that the student comes across including blood gases, renal failure, shock and body fluid maintenance.

The **Handbook Of Anaesthetics & Perioperative Care, Ponte & Green (Ballière Tindale, ISBN 0702016896 £14.95)** is a useful book for the budding anaesthetist! Don't leave home without it (if you're doing anaesthetics that day and going to theatre. If you're not, it will probably be OK).

Richard Littlewood

Paediatrics

A new 'in your pocket' guide to paeds for medical students: **Paediatric History and Examination, Lang & McIntosh (Ballière Tindale, ISBN 0702018090, £4.95).** This a is concise introduction to the clerking of children. The book is only 89 pages and is about the size of an Oxford Handbook. Pages are small and the quick and easy to read text means that this is intended as a good, low stress revision or quick introduction to the subject. It is aimed at undergraduate students; if you're a post-

graduate paediatrician and you need this book for revision you're in trouble! The guide is really at the level of the undergraduate.

The chapter on history taking briefly summarises the most important questions in each system of the body. On the whole, the history section is simple and quite snappy. The amount of detail for some systems is such that it is only a summary. In such a small book this is bound to be the case. The book would be improved if there was space for readers annotations. Examination of the infant is presented in a similar manner with diagrams to help. The authors remind the reader in the introduction to examination that '...maximum information can be obtained gently and efficiently with the minimum of upset....'. Ummm...

Neonatal clerking is covered: the basics of the first day check are outlined in the examination chapter. A good pictorial description of developmental assessment from neonate to infant is given along with further chapters and appendices covering child abuse and immunisations.

A useful on the ward/battlefield summary of how to clerk children and stay out of trouble. It's cheap and cheerful; while you won't want to marry it you may be pleased to find it in your pocket.

Richard Littlewood

The Healing Art

The Healing Arts: An Oxford Illustrated Anthology, Downie ISBN 0192623192, £18.99.

This book is the result of a collaboration between a professor of medicine and a like mind in the Faculty Of Arts. It arises from an attempt to broaden the exposure of medical students and health care professionals to arts and especially to art associated with medicine. It is a miscellany of articles, poetry, reproductions of cartoons, drawings, sketches and paintings. Many aspects of the healing arts are included in the book and the artists are selected from the famous and not so famous, the interesting and the unusual. Sources are wide spread: works are present from writers such as Plato and Socrates to Wilfred Owen and artists ranging from Leonardo da Vinci to Sir Roy Calne.

Initially this book seems to be a coffee table extra but it is interesting on further inspection. If you are interested in literature and have a little spare time you may like to take a look.

Richard Littlewood

Polyclinic Development at St Thomas'

The development of a Dental Polyclinic, located at St Thomas' but an integral part of the Dental Hospital and School, is well under way.

After its last visit, the General Dental Council recommended that final year students undertake some of their training in facilities more remote from the Dental School. The new Polyclinic will represent this opportunity for students to undertake the examination and treatment of patients in circumstances akin to those they will experience once in practice. The Polyclinic will be headed by Mr Mark Woolford, Senior Lecturer in General Dental Practice and the Polyclinic is due to open in March of this year.

The existing Oral Surgery clinics will be moving to the new facility which it is hoped in due course will be fully utilised by a variety of specialties.

I would like to dispel the concern of some staff that Guy's Dental Hospital is somehow under threat by the establishment of dental facilities at St Thomas'. The Dental Hospital and School have in fact exploited the union of the two hospitals to provide an additional facility for its staff and students without having to go outside the Trust for the purpose. Staff will be given the opportunity to visit the new facility and find out more about it as the project nears completion.

Richard Jones

Will you see me off, when you can't afford to keep me on?

Hardly had the ink dried on the paper notifying of my own premature retirement, in which I am not alone, then I notice there is a great national and local concern about the increasing population of old people, and the impact this has on nursing.

Time was when, as it was then known, 'geriatric nursing' was very much the Cinderella of the profession. Now 'Care of the Elderly' has a higher profile, and merits its own section in the classified vacancies section of the nursing press and a host of research publications. Resources from the government for the NHS side of this nursing care are under extra pressure in the present climate of cost cutting wherever possible.

Those who have not yet reached retirement age, and those like myself who have only recently joined this throng, must be worried about how much money there will be to keep us going. And 'going' is very significant a word. Since 1980, folk living in the UK who are over 75 years old have increased by 28%. And if we are among the crystal-ball gazers, of those who make projections into the 21st century, there is no limit to the figures of how many will be living longer, with a decreased paid workforce group on which they can rely. The problem of ageing poses many ethical and economic dilemmas. The many chronic conditions which coincide with old age, Parkinson's, Alzheimer's, et al, are the results of a decline in disease which once saw many into an early grave.

A prominent local funeral director, Mr Albin of Rotherhithe, who has undertaken the care of many a cadaver from Guy's is now extending this care by offering (at nearly £17,000) cryogenesis, whereby the body is 'deep frozen' until mortal resurrection techniques are available. So Vera Lynn's call to 'meet again' may now extend beyond the grave!

The promotion of health and fitness, and classes to keep the elderly on their toes, is widespread. The almost universality of the no-smoking lobby may succeed, and life will extend still further. If all this means the elderly are able to care for themselves in their own homes, then this may be good. Though even this leads to longer drawing of pensions, other financial assistance, free bus travel, and other pecuniary drains on state and private funds, which could become excessive.

The Community Care Act of 1993 has meant that nurses have a very different role in caring for the elderly, than hospitalised nursing used to present. There are 6.8 million people, 79% of whom are over 65 years, who are cared for by relatives. This is

a very large number of clients or patients, and an equally large number of relatives who are dependent on the back-up care and help which can be given by nurses. There is, not before time, a Private Members Bill going before parliament, with the aim of improving the relationship between Local Authorities and carers.

It may be traditional to condemn youthful callowness; Aristotle was not immune. But some OAPS, oops that's not PC, I mean, of course Senior Citizens, can be extremely trying. I recently overhead one arrogant old man, when confronted by an orderly crocodile of children, yell 'beep, beep', and then hurled the abusive 'bunch of hooligans, the lot of 'em', at this innocent group. I had the feeling he was the type, none too popular, who would incessantly shout, 'nurse, nurse' if his bedbound wants were not instantly met.

So, the risks of growing old are considerable. Nurses are having to, move from their disease related focus towards becoming part of multi-disciplinary teams, which can use such models as Orems to promote carer involvement. This is a questioning and discussion process. If this does not happen, rehabilitation of those who can benefit will not occur, and we are confronted with the familiar situation of beds blocked in acute units which are better equipped for other uses.

Nurses have to help, in the community, in training carers to use, amongst other aids, hoists. Indeed, even in the hospital environment the RCN now recommends that, without mechanical hoists, two nurses should not be expected to lift a person who weighs over 8 stone. This figure has drawn gasps from some nurses who remember lifting rather more more in the past! But nurses have a bad record of back injury; something like 70% of health worker injuries reported to the Health and Safety Executive, are associated with poor ergonomics in this this task.

I sometimes wonder what virtue there is in living to a great age. Nowadays, fewer of us believe in the 'grim reaper', except as metaphor; and, I concur with the view, that this life is all we have, so there's a burgeoning need to make the best of it. As I write the news of Peter Cook's death, at an age close to my own, has just come in. He lived a very 'unfit' life according to reports and not in tune with health promotion policies - but maybe in his case there was more quality than quantity? I hope that I will be bold enough to ensure that my life does not drag on too long, when it may impinge disadvantageously on others, and bore me as well. And I may need a nurse to make sure about this.

Denis Cobell.

James Walker Mansie LDS FDS MRCS LRCP

Emeritus Dental Surgeon, Guy's Hospital
President Guy's Hospital Boat Club (1956-1986)

James Walker Mansie , who died on 14th November, the eve of his 86th birthday, entered Guy's in 1926 from Lycee St Omer and the Perse School and qualified in medicine and dentistry. He was awarded the Guy's Travelling Scholarship and Scholarship to North Western University in Chicago in 1934, enabling him to study teaching methods in 13 US and Canadian schools and to engage in postgraduate work at North Western. After returning to Guy's he progressed through various teaching appointments in the Dental School - Demonstrator in Prosthetics and Dental Histology and he also became Dental Surgeon to the Evelina Hospital.

He continued to serve Guy's during the War both on the Guy's campus and at the wartime outpost in Tunbridge Wells. He was made Assistant Dental Surgeon to Guy's Hospital in 1947 and Consultant in 1954. The diploma of FDS RCS England was conferred on him in 1948 and he examined for the Royal College and the University on many occasions, and on one of these, a female candidate after a viva with James reassured those waiting outside by saying 'Don't worry, he is just a cuddly old musician'. He practised in Harley Street for much of his professional life.

James established a special place in the hearts of hundreds of students in his long career at Guy's and although the age gap between him and his students inevitably widened, he remained young in heart and maintained an easy relationship with them. The anecdotes about him are legion. Some will remember his sessions in the old Gas Room, where he sat hidden by The Times, emerging only if things got difficult, to sort out the problem with a few deft movements executed in silence with a look of innocent surprise, only to disappear behind The Times once more. He was an unconscionable practical joker, taking great care in planning with no detail overlooked; only a few went badly wrong.

His love for and loyalty to Guy's were unsurpassed; recognised by his appointment to the Board of Governors in 1968, his thirty year Presidency of the Boat Club and four times Presidency of the Dental Society. He was a very popular after-dinner speaker who could bring the house down with words apparently chosen with difficulty and interspersed with long pauses. Throughout his life he

was a great reader and his letters, the flavour of which was only slowly released as one deciphered his meticulously illegible writing, often contained a quotation from a book or a newspaper cutting. Above all, James was a wonderful friend; excellent company whatever the occasion, whether walking in the Hebrides, fishing in Ireland, at a museum or art gallery and at a pub almost everywhere.

In 1935 James married Catherine Enid Kirkpatrick, who died in 1975. He is survived by two daughters and three sons; his eldest son, Duncan, qualified in medicine at Guy's in 1962.

Declan Anderson

A tribute to Mr James Mansie

I would certainly not be alone in considering James Mansie to have been one of Guy's greatest consultants. James' distinguished and immaculate appearance, hesitant speech and clinical skills epitomised a teaching hospital consultant for many, but for countless hundreds of student members of the Boat Club he was very much more. Ever present when needed, discrete when necessary, generous to a fault, even a willing scape goat to divert the police at times, in short a true friend. That the club is now the envy of the University and enjoys more success than any other at Guy's is largely due to James. He was elected President in 1956, a position he held for 30 years. During that time, he literally held the Club together during lean spells and rightfully enjoyed many glorious years. For our part, we knew how fortunate we were to have the best President at Guy's and realised his fundamental interest was to make student life as enjoyable and fulfilling as possible.

Although built like a coxswain, it would be fair to say that James never really mastered the skills needed to coerce eight oarsmen to apply their aggression in a controlled and cohesive fashion. It is perhaps for that reason he recognised this special breed of man as a distinct entity, almost a separate gender, as he always started any speech or lecture with the immortal words 'Ladies, Gentleman and Coxswains.' However, James had his own unique and unforgettable style when steering a boat, as many of us who were honoured to row in his Gentlemans VIII in the Tideway Head of the River will never forget. James always took the scenic route, moved quickly out of the stream to help other boats pass and always had a kind word for the anglers on the bank, many of whom failed to appreciate his interest in both their lines and catch. He also

came fully equipped, usually with a periscope and always with a bottle of scotch lest anyone got thirsty en route! It would be unfair to James not to state that the intention of this crew was to gain the ultimate accolade - to come last but in style.

James and his family were always present at regattas. They would be one of the landmarks on the course, a point at which the Guy's coxswains could rely on hidden reserves of energy becoming available to the crew as they responded to the Mansie's cheers. Similarly, he never missed congratulating a victorious crew or sympathising when their luck was out. The club in its turn honoured James and Enid by naming several boats after them.

James was a boxer in his student days. In a report of the Novice Boxing Competition published in the Gazette of 1927 the commentator wrote 'the outstanding match of the evening was between JF Paterson and JW Mansie in the Fly weight division. The contestants both seemed regardless of the punishment they received.' The referee on that occasion, with the agreement of the competitors, decided that the fight should be restaged on the night of the finals. In the final it is recorded that 'the crowd applauded the contestants savage attacks' but James, alas, lost the verdict. There was a prophetic conclusion to the report 'if these two continue to box this way, we are safe in predicting their futures as distinctly good'. James' future was good, very good indeed and so were ours, enriched and enhanced by his interest and friendship. The Boat Club mourns the loss of our great, little man. We all loved him so dearly.

Michael Gleeson

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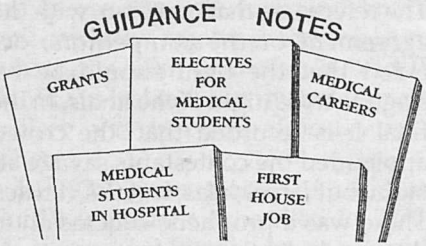

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Next Meeting:

14 February 1995

"Student Assistantships"

Rugby

10th December 1994, Guy's Hospital 5th xv vs Blackheath 5th xv. Result: Won 30-10

An air of gloom and despondency greeted me upon my arrival at Honor Oak Park, on a fine December morning, that is now indelibly imprinted on my memory. As is so often the case with the 5th's, on paper we had a full team but in reality, we had nothing like one. Also for some inexplicable reason the opposition had not yet arrived, even though they had spoken to Graham Bevan only an hour earlier. Eventually the team started to arrive in dribs and drabs, although Kieren was over an hour late, (and they say I've got a punctuality problem). Then suddenly, on the dot of Eleven o'clock, Blackheath '5th xv' arrived muttering something about being told the kick off was at 11.30. As some of the team had still not managed to get there, we made up a team from those that had, and some other members of the club who happened to be at the ground at the time and were resting between league games.

Ten minutes in to the game and it became apparent that, for most of the time, we were keeping the ball behind Blackheath's 22 and it was then that I allowed myself a grain of optimism. A great deal of fearsome mauling, brought us to one of the many scrummages' that we managed to win. Our pack, being about equal in size to theirs. A powerful pass out of the scrum, by Nevil Young, brought the ball cleanly to the backs and to Graham Bevan, who scored the first try, it was unconverted. Some more frantic mauling brought the ball to Ugo who, after some impressive running, scored the second try of the game; this too was unconverted. The third try, again not converted, was scored by the quick thinking and movement of Finbar Sullivan; this simply annoyed the opposition. And like a herd of enraged cattle, Blackheath gallantly fought back and scored a try, which as was becoming the trend, was uncoverted. After three minutes from half time, Ugo again scored another uncoverted try, bringing the score to 20 points to 5.

Half time saw the loss of Waz, due to injury and Billy Challacombe, due to a pressing appointment at Twickenham. They were replaced by Kieren McCann and Tony Rose. In the second half, Blackheath vainly tried to even the score a little, but their efforts simply weren't enough to over power a team now flushed with success. There then followed a ferocious battle in the line out, which eventually led to the ball getting out to the backs. The fifth try, scored by Graham Bevan again, saw some of the most recondite running I have ever seen, but then I suppose that's not so surprising. This really was the overall flavour of the game, not a great deal of kicking, with possession

changing in the set pieces and a tremendous amount of very evasive running. A style of rugby that the fifth's do at least aspire to.

Blackheath then fought back with another bog standard try; this as all the others was not converted. Ten minutes from no side saw David Gibson leave the field because of injury; he was replaced by Nigel White, just in from Basingstoke for a few minutes of light rugby. In the dying moments of the game, a scrum close to the posts gave our number eight, Ross Llewellyn, a chance to carry the ball across the line, This he did; however it, like so many, was unconverted.

I'd like to offer a special thank you to all those players who slummed it for the day, a great victory for the 5th xv of the World's oldest Rugby club. How sad it will be, to see that title go to our opponents.

Team; T O' Dwyer, W Simm, K, McCann, F Sullivan, H Evans, B Challacombe, T Rose, G Tsolakides, T Bird, R Llewellyn, N Young, A Hall, D Gibson, N White, S Hughes, F Ugo, N Dennett, G Bevan.

Harry Evans

23rd November 1994 Honor Oak Park, Guy's RFC v Patensie (South Africa)
Result:Lost 5-6

During the summer on their successful and entertaining 150th season tour to South Africa, Guy's played in the Northern Transvaal at Patensie. The Club were royally entertained and had civic receptions in Port Elizabeth and Jeffrey's Bay. Now it was our turn to host the Afrikaaners of Patensie who brought over a mixed side, part of their long term policy under the guidance of their President, S P Farrera for integration between the two previous white and black clubs of Patensie. At the previous encounter Guy's had lost narrowly 5:0 in a match with several injuries not unconnected with Guy's gallant defence on that day against a much bigger pack, the tactics of using the back row as a battering ram.

On a rather gloomy but dry day at Honor Oak Park the Patensie team adopted much the same tactics with a huge pack and crashing runs setting up the ball for the large forwards to follow on to. However as before Guy's tackling in the first half was immense and they managed to obtain a reasonable share of the ball by this tactic and taking two against the head in a tight scrum which was surprisingly solid. Guy's were playing a policy of running everything with the ball passing entertainingly through many pairs of hands back and forth across the field. This led to their first try after where one ball by the forwards was transferred quickly across the field for Ugo to score in the corner. Guy's were feeling the pressure in the line out also where the bigger Patensie forwards were winning

most of the line out ball, but the technically superior rucking and setting up of the ball in the loose winning the Guy's side sufficient ball to be optimistic about. Half time score 5-0 to Guy's.

Second half play followed the first half with the Guy's side showing bags of confidence in the handling and impressively good technique with the pack holding the much heavier opponents in the tight, the forwards setting up the ball in hand in the mauls and on the ground ruck, with little fear for their own safety and the backs passing with confidence and speed along the line to release two wing Schaefer and Ugo. However a penalty offence against the backs for hanging onto the ball when they were trying to run it out of their own 22 to a penalty goal for Patensie. One lovely back move almost brought a try when Ross Llewellyn at No 8 picked up the ball and took the scrum half's tackle to leave John Morgan free to race up and take the blind side flankers tackle and put Ugo away towards the corner. He ran 40 yards before being tackled just short, of the line. From the ensuing ruck Patensie were caught offside but Gush hit the posts with the penalty attempt. The possibility that this could be costly crossed our minds when within a minute Patensie had kicked another penalty to go into the lead. A match which had hitherto been played in very good spirits was then marred by two unsavoury incidents. First, Billy Challacombe laid the ball back onto the ground and the Patensie flanker quite deliberately came over and stamped on his head. It was unclear why the referee did not immediately send him off but a few minutes later another player performed a stiff arm tackle on Pat Gush coming through and was dispatched from the field. It transpired that a general warning had been given to the South African team that the next player to commit a major foul would be sent off and unfortunately for them the fly-half was caught with a retaliatory punch and was sent off whereas the real culprit stayed on the field. The remainder of the game was played out in a somewhat tense atmosphere with Guy's having several penalty chances to convert and win whereas Patensie converted their one chance and rather unfairly and certainly undeservedly ran out winners by 6-5. As their President noted the better team had lost on the day but that would be small consolation to Guy's team who had played extremely well and lost.

Team: Was Slim, Pinder, Lutz Hostert, B Challacombe, E Barrio, G Ryan, R Llewellyn (replacement W Llewellyn), P Angus, J Morgan, P Gush, M Griffiths, J Davies, Ugo Ekeowa, W Schaeffer, J Burt.

SJC

26th November 1994, Guy's Ist XV v Old Wimbledonians at Wimbledon
Result:Won 24-15

Three years ago Guy's first met Old Wimbledonians in a league game. Wimbledonians were unbeaten and averaging over 30 points a game with the help of an ex-Irish International.... In a tight league game Guy's lost 11-5 and Wimbledon were promoted and Guy's stayed in London 3. Last year at HOP in a friendly fixture Guy's narrowly won. Old Wimbledonians remain comfortably ensconced in London 2 and Guy's in London 3 but we were anticipating a close game.

That is exactly what it turned out to be. Old Wimbledonians dominated the line out and with this possession ran the ball frequently along the back line. However Guy's defence were a match for them and after a fine batch of interpassing Murphy put the first points on the board with a try in the corner. Both sides were showing good technique in the loose and protected their possession well. A penalty to Old Wimbledonians for lifting in the line-out and this was followed by an absolute gift try when in attempting to take a short line out on our own 22 the hooker misread the signal from Barrio who was in fact about to adjust his shoelaces and passed to the opposition flank who gratefully accepted the try. The half time score was Old Wimbledonians 8 - Guy's 5.

The second half was played in the same hard fought fashion and the game was evenly contested. Guy's ought to have scored when a glorious move through at least 12 pairs of hands, back and cross the field twice was eventually thwarted. Instead of testing his winger Bevan chipped over him. However a few minutes later he did put the winger to the test when after a switch move the ball was passed swiftly across the back line and he found himself with a couple of metres which to beat the full back, which he did for a try converted by Ronan. Guy's lead of 12-8 was extended a few minutes later by the most popular try of the day when Greg Ryan dashed away from a quickly taken free kick, sold an outrageous dummy and scored under the post against his old school's old boys. The try was again converted by Ronan bringing the score to 19-8. Guy's now had their tails up and were beginning to play very attractive and the lead was extended to 24-8 when the ball was eventually given to Ugo who scampered over in the corner. Old Wimbledonians had the last word when after a high kick their forwards engulfed the Guy's fullback and although the ball came back on the Guy's side there was confusion about whose responsibility it was to take it since the scrum half had been caught up in the maul and Old Wimbledonians took the opportunity to

come through and score a try under the posts.

Nevertheless the final score of 24-15 with 4 tries scored to 2 was a very satisfactory result and the manner in which the victory was achieved was most pleasing. The forwards showed excellent technique in their ball retention and supported the backs extremely well. The backs were full of running and John Murphy is proving a worthy successor to Richard Docker at scrum half. Mark Jenkins in the centre is improving with every game and outside him Al Jones continues to defy the years with excellent positional play and deceptively fast running. In the forwards Lutz Hostert at Prop displayed fine form which suggests that the captain George Tsolakides is going to fight hard to regain his place and Challacombe and Barrio in the second row who again showed what a hardworking and powerful pair they are. In the back row, Greg Ryan had an outstanding game against his former club.

Team: Lutz Hostert, Dai Evans, James Birt, E Barrio, B Challacombe, G Ryan, Scott, Lemmings, J Murphy, Ronan, G Bevan, A Jones, G Jenkins, Ugo Ekeowa, Justin Burt.

SJC

UMDS Boat Club

Janousek Fours Head

The first race of the 1994/5 season was once again the Janousek Fours Head of the River race. For the last couple of years, the club has used this race as a practice race for the Fours Head which follows in two weeks time, and this year was no exception - the mens first IV hoping to go one better than the second place achieved last year. Despite only having rowed together for a couple of weeks previously, the crew were looking forward to racing. The race itself was rowed in blustery conditions which did little to help our cause, although our rigorous training programme ensured that we could keep the pressure on for the entire duration of the race, rating around 30 for the whole course. Despite the lack of practice, we were confident that we had set a good time, although in the end a time of 13:02 was 'only' good enough for second place, the RAF proving that they had extra wind beneath their wings in winning the event by 12 seconds. An improvement of 40 seconds on last years time, however, was encouragement for the forthcoming Fours Head.

Fours Head of the River

UMDS entered two boats for the Fours Head: the mens four, that had raced in the Janousek Fours, and a ladies coxed four. The weather for

this race was much improved compared to the previous race, and the crews took advantage of this to perform very credibly. Starting at position 290, the ladies rowed a stylish race which saw them return a time of 26 minutes, enough to finish in the top half of their division, against national crews of a very high standard. Further back, the mens IV (at position 312) raced off the start rating 30, easing the rate down and the power up over the first couple of minutes. Flying down the course, overtaking eight boats on the way, saw an excellent time of 22 mins 17 secs being posted - enough to finish fifth in the division, a credible performance given the opposition, and gaining revenge for our defeat 2 weeks previously by beating the RAF by about half a minute. Crews: Sharon Payne, Rachel Tennant, Amanda Bond, Nina Barrows and cox Ollie Foote; Dylan Jewell, Sidd Nene, Steve Arnold, Richard Baird, and cox Darmesh Mistry.

University of London Regatta

The University of London regatta was the first opportunity for our committed freshers to try their hands at racing. The previous weeks of coaching and a training day overseen by captain John O'Leary had prepared them for the races and they were keen to demonstrate how they had progressed since learning to row just 8 weeks previously. The mens novice VIII rowed superbly in their two heats, leaving the opposition trailing, and were very unlucky to lose narrowly to UCL in the final. Five members of this crew however, were unfairly beaten by a Barts crew which had 'only rowed a few times previously' according to their captain, when the club complained about their status, in the novice coxed fours. The senior mens squad was very successful throughout the day, winning the open pair, where both UMDS crews met in the final after beating their opposition; the open four, who saw off the competition over three rounds of heats before thumping Kings in the final by about five lengths; and the open eight, again beating Kings, this time in the final of the Allom Cup race, by an equally emphatic three lengths.

Exams and peripheral attachments unfortunately prevented the ladies first VIII from entering the regatta, but honours still fell in the ladies direction thanks to the freshers. The novice four were unlucky for a blade to come out of the gate whilst leading their heat, displaying style that would otherwise have carried them to victory, but no such problems hit the novice VIII who blew their opposition into the weeds whilst storming to victory by five lengths. By the end of the days racing, UMDS had won more races than any other club in UL, winning back the Allom Cup last won two years ago by GHBC.

United Hospital Regatta

Having taken on and beaten the rest of the University of London, the whole club was looking forward to racing the other hospitals the following week. The UH Regatta was being run by ourselves again this year, and this meant that some minor problems inevitably arose, but due to the efficiency of Andrew Hobkirk and his team, the Regatta was completed by the end of the day when captain John O'Leary collected the Steadman's Challenge cup presented to the club with the best team performance in the regatta. Right from the word go, when the mens open four knocked up the first victory in their heat, was the pattern set for the rest of the day. By the end of the day UMDS had notched up wins in the mens open VIII, mens open IV, mens open pair, mens open scull, mens junior IV, mens novice IV, mixed open VIII, mixed junior VIII, mixed novice VIII, womens open pair, womens open scull, womens novice VIII, and womens novice IV (this time beating their opponents convincingly). Other victories would surely have come too, if it were for the fact that no other hospital dared enter a crew against our womens open IV, and if our womens open VIII had been at full strength. As it was, this crew lost by a mere half a length to the Royal Free. The mens junior VIII would also have won if they had not been disqualified for lateness whilst waiting for members of their crew to return from another race. Perhaps the most exciting race to watch was that between the mens novice four and their opponents Barts, still insisting that they were novices. After the disappointment of losing to them last week, our novices were determined to have their revenge. From a good start by both crews, our novices gradually managed to pull away, and by sheer determination, had opened up a gap of clear water between themselves and Barts by the finishing line. The winning margin of one and a half lengths was just reward for all their efforts.

It was particularly pleasing for all of our talented freshers to win at least one tankard in the various races, as a reward for showing such keenness and commitment to the sport. Special thanks must be made to the helpers on the day: Andrew Hobkirk, Matt Gray and Richard Baird for their organisational skills, and all our drivers, marshalls and finish line judges: Chris Stone, Charlie Sherwin, Emma Helm, all regular members of the club who helped, and Mr Michael Gleeson, UMDS and UH president for coming to support us and for presenting the prizes. Looking to the future, the club seems very healthy and members are looking forward to racing in the coming heads.

Steven Arnold

Deaths

LIDDIARD, Sally Veronica, SRN (Guy's 1962-1965), nee Warren, of Hatherleigh, Devon, and Jersey, Channel Islands. Died peacefully at home on December 1st 1994, aged 51, after a long illness most courageously borne. Beloved wife of Paul, LDS, RCS Eng (Guy's 1957-1965) and loving mother of Nicola and Timothy.

Dr CRAIG, R A (1941), died 3rd August, 1994.

Dr MATTHEWS, John Chester, MRCS, LRCP, LMSSA, LDS, RCS (Eng) died 24th December, 1994.

Dr TILLMAN, Wolf George died in the early morning of Tuesday 3rd January, 1995.

BDS Qualifiers

The following students qualified BDS University of London in December 1994 and are life members of the United Clubs.

DEADMAN, Leigh Curtis

GILL, Gurminder Singh

QURESHI, Miss Rakhshi Zafar

LDS Qualifiers September 1994

DEADMAN, Leigh Curtis

QURESHI, Miss Rakhshi Zafar

South Wales Guy's Hospital Society

The above Society will be holding its annual dinner at the Park Hotel, Cardiff on Saturday 18th March, 1995 on the night of the Wales vs Ireland match.

Membership of the Society and the attendance at this function is open to Doctors, Dentists, Nurses and Physiotherapists, male and female, who have received their professional training at Guy's or UMDS.

For further details please contact:

Mr D E Sturdy, MB, MS, FRCS,
22 Stow Park Circle,
Newport,
Gwent. NP9 4UF

Old Student's Day 1995

The Old Student's Day will be held on Friday 8th December, 1995 to which Guy's old students will be invited.

Aid for Bosnia and Croatia

In early March another aid convoy will leave for Bosnia and Croatia where there is still a desperate need for all types of relief supplies.

Can you spare any medical equipment (including spares and consumables), drugs, warm clothing, blankets, toys or wool; in fact anything to relieve suffering and help rebuild these countries?

If so please contact Pete Glasper on 071 955 4143 or 0344 876 073.

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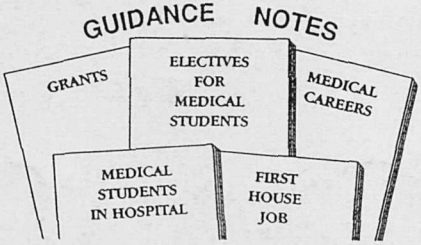

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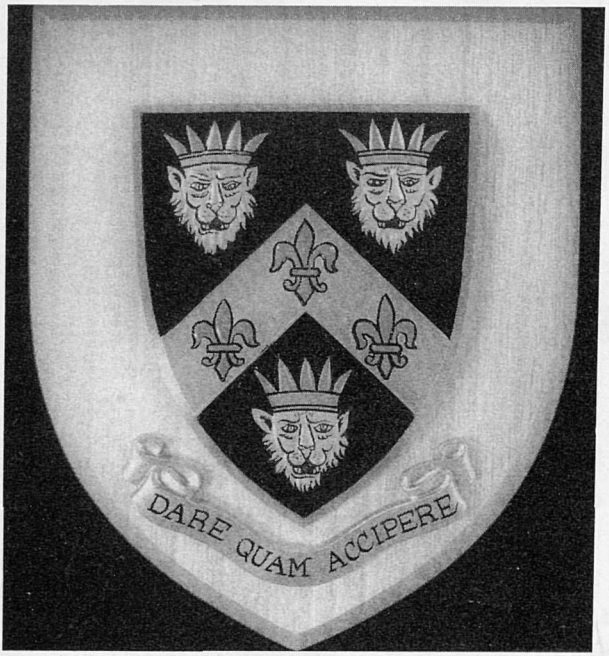

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Passim

A great deal has happened in the previous few weeks concerning the campaign to save our great hospital. The target to reach over one million signatures has been amply surpassed, with 1 040 000 signatures being collected so far. This was handed in to Number 10 Downing Street on 9th February. Let us hope that the powers that control our fate have the sense to see the devastating effect these reforms to Guy's are going to have. Another political figure has been to see for himself the effect on morale that the proposed changes are having on the hospital; namely Tony Blair MP, leader of the opposition. The media has also been picking up the story of Guy's. Many will have noticed the increased coverage of the news about Guy's on local and national television.

There is a saying: what is greater than knowledge is experience. This is very pertinent to our situation. People have said much about the ways in which our hospital should be run and changed. They may have the knowledge, but many lack the experience of having worked in an institution like Guy's. The reforms that apply not only to Guy's in isolation but many other hospitals in London are wrong. People can see that they are wrong and want to do something to put right this injustice. The powers that be feel that by rushing through the changes perhaps people will not notice as much, like a nurse pulling off a plaster from a cut, 'if I pull it off quick enough it will not hurt as much'. We need to let people know that it does hurt, not only does it hurt London but it hurts the country as a whole.

The pressure is on the Government to do the right thing and change its stance on Healthcare in London. We must not let Guy's be another casualty before this happens.

Thank you

Dear Sir,
Words fail to fully express the Campaign's gratitude for donations received. The decision to ask for more money was not taken lightly and I can assure you that all gifts will be spent carefully and effectively.

We will continue to keep you fully informed about our progress.

Yours Faithfully

Michael Gleeson MD, FRCS
Treasurer Save Guy's Campaign

Spirochaetes

Dear Sir,
I am writing a history of The Spirochaetes Hockey Club. Would any readers who have any facts, stories or incriminating photographs concerning the early years of this institution please contact me?

11 Towton Rd
West Norwood
London SE22 9EE
or e-mail:
tgardner@cix.compulink.co.uk

I say early years, but come to think of it I can't remember too much about what happened over the past ten years--so if someone could fill me in a little, I would be eternally grateful.

Yours Faithfully

Tony Gardner
Spirochaetes Captain 1987

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

Campaign Update

SOUTH LONDON HEALTH CARE NEEDS PLANNING - NOT PR

By now most people living in South London will know that there are plans affecting their hospitals. The Guy's & St Thomas' Trust has to try to meet their health needs over the next ten years. The consultation over their proposals closed on February 17th. Local people have a right to expect that they will have continuing access to the best possible care. This calls for sensitive open minded and careful consultation and planning. Dogma and preconceptions have no place in such a process.

Instead what the public have been offered is a series of documents amounting to propaganda from the Trust. These are full of PR-speak with phrases like 'exciting', 'innovative', 'far-reaching' or 'into the 21st century'. The latest of these papers are headed 'Accident and Emergency Services' and 'Focusing on Planned Care'.

'Planned Care' sounds impressive, as if there was something new in the proposals. In fact it is something which is happening in almost every hospital in the NHS. More and more patients are being treated without a hospital stay - as day cases, with or without so-called minimally invasive therapy (keyhole surgery and similar procedures). Better organisation of clinics can make it possible for one hospital visit to provide a complete diagnosis and sometimes the appropriate treatment.

This is exactly what was planned for in Philip Harris House. What was also planned was that inpatient care would be in the same area as the outpatient clinic. It would save space. It would save having two lots of equipment. It would mean that outpatients who become inpatients would be treated by the same people, not different people in a different hospital. This is the planned care which the Trust is throwing out.

The Trust talks as if 'Keyhole Surgery' means that fewer beds are needed in hospitals. Much surgery can be done like this but not all - heart operations or hip replacements for example. And the real problem is for acute medical admissions - the heart attacks, strokes and pneumonias, especially in the elderly. For these conditions the length of hospital stay has not changed and the ageing population means that this kind of problem is increasing. At the same time in south London there are too few nursing homes and residential homes to care for elderly patients as they slowly get better. This is why patients still wait for hours in Casualty Departments when no beds are available.

So the Trust's planned care will mean:

- An A & E department at St Thomas' capable of handling 120,000 patients

a year but only half the hospital beds needed for the admissions which will result.

- Many elderly patients and their relatives travelling to a hospital sited at the far edge of the district in which they live. Even those who live in Lambeth will not be all that lucky, since they will have to compete for their beds with patients from Bermondsey or Deptford.
- The only unit for day surgery in the UK with no back up from Intensive Care and no resident physicians to deal with medical complications such as heart attacks.
- A series of moves and new hospital buildings which will take up to five years, cost at least £54 million and which will mean some departments shifting from one hospital to the other and back again. All this will be at the same time as the newest hospital building in the UK is waiting to be used for the purposes intended: if it were, none of this merry-go-round would be needed.
- No coherent plans to ensure that when a patient is seen in one hospital and admitted to another the notes and X-rays will be in the right place at the right time. This is a major problem within any hospital, yet the Trust has barely started to think about this vital matter.
- A Diagnostic Centre which is spoken of as if it will have new high-tech equipment. In fact all this new equipment is already at Guy's and is benefitting patients even now. The main difference in the future is that because there will be hardly any in-patients this equipment may well by under-utilised.

These are just examples of the 'shoot-from-the-hip' approach which the Trust has shown in relation to the vitally important matter of health care planning. The people of South London deserve better and the Save Guy's Campaign is fighting on their behalf. In the meantime a glossary of the Trust's PR terms may be useful:

- 'Exciting' means 'it will cost less'
- 'Innovative' means 'untried'
- 'Far-reaching' means 'will have extensive effects, but it is impossible to say what'
- 'Into the 21st century' means 'until it becomes obvious that it is not working'.

Threat by surgeons

Surgeons in the Trust have threatened to halt all operations if the Intensive Care Unit closes down. The doctors said they would refuse to carry out surgery without the back-up of an Intensive Therapy Unit which is due to be transferred to St Thomas' as part of the proposed merger of the two hospitals. But surgeons fear lives could be lost if ITU beds are not on hand in case operations go wrong. Ear Nose and Throat specialist Michael Gleeson said 27 out of 30 surgeons surveyed backed the boycott.

He said, 'I wouldn't like to work in a hospital where they haven't got a single ITU bed. Services should interlink so that you haven't got to travel a mile to find one.' Mr Gleeson said there was no major hospital in the Health Service without intensive care facilities.

A new 16 bed state-of-the-art ITU was due to be housed in Guy's £150 million Philip Harris House which is nearing completion.

A Guy's and St Thomas' spokeswoman said, 'Discussions are taking place with doctors to work out what surgery can be safely provided at Guy's.'

Down's Syndrome Programme

A Down's Syndrome Screening Programme has been introduced at Guy's for all pregnant women between 15 and 20 weeks. Although the incidence of Down's syndrome increases as the mother gets older, only 30% of cases are born to women over 35. Biochemical screening can detect around 60% of pregnancies affected by Down's syndrome.

Face-lifting

Work begins on a project which will enhance the public areas where patients and visitors enter the Hospital. The entrances of New Guy's House and Guy's Tower are to be enlarged into one large foyer which will also include an entrance into Phase III.

'The work to improve our entrances and patient reception areas will improve the first impression areas when patients arrive at the Trust hospitals,' says assistant facilities director, Sandra Carnall.

The First Heart Transplants in the United Kingdom, 1968 - 1980

The Role of Guy's Graduates

An extended version of a brief article published in the 'British Transplantation Society Newsletter', December, 1994. This is the first part of the article which will be concluded in forthcoming Gazettes.

After graduating from Guy's at the end of 1963, and fulfilling three house appointments there, I spent a year teaching anatomy in the USA whilst studying for the Primary FRCS examination. In early 1967, at which time I was a senior house officer in Accident Surgery at Addenbrooke's Hospital in Cambridge, I made the decision to spend a period of time in full-time research, preferably in a cardiovascular surgical topic, in an effort to obtain a PhD degree.

This decision was made partly because of my enthusiasm to get involved in experimental research at an earlier stage than is usual in a surgical career, but also - I must admit - because a research position would allow me sufficient time to pursue my interest in the sport of rowing before I became too old to be proficient!

'In early 1967, at which time I was a senior house officer in Accident Surgery at Addenbrooke's Hospital in Cambridge, I made the decision to spend a period of time in full-time research...'

My first enquiries were with Dr Edward Proctor in the Thoracic Surgical Research Unit at Guy's (which was then under the direction of the late Lord

Brock) who was carrying out some excellent research in the field of organ storage (1). We were considering submitting an application for a grant to pay my salary when an advertisement appeared in the medical press for a research fellowship at the National Heart Hospital - then situated in Westmoreland Street, London W1 (and now merged with the Royal Brompton Hospital) - to work on the topic of transplantation of the heart and lungs. Several 'knowledgeable' surgeons and surgical researchers (including some on the staff of Guy's) advised me not to apply for this post as it was perceived that heart-lung transplantation was many years in the future. Nevertheless, I contacted Mr Donald Ross at the National Heart Hospital, and he invited me over to discuss the post. Donald Ross was also on the staff at Guy's and indeed I had worked for him and Lord Brock as a house surgeon at Guy's some two years earlier.

'...funded by a grant to Mr Ross in collaboration with Donald Longmore (a Guy's graduate) and Sir Thomas Holmes Sellors to develop a technique and study the feasibility of transplantation of the heart and both lungs.'

Research at the National Heart Hospital, 1967 - 1969

The surgical research fellowship was funded by a grant to Mr Ross in collaboration with Donald Longmore (a Guy's graduate) and Sir Thomas Holmes Sellors to develop a technique and study the feasibility of transplantation of the heart and both lungs. It was Donald Longmore, a surgically-trained clinical physiologist, who was actually supervising the experimental work, and to him must go much of the credit for having the vision and enthusiasm to set up a research programme in this field at such an early stage. Donald Ross and Sir Thomas Holmes Sellors, the two surgeons at the National Heart Hospital, were not involved in the day to day work in the laboratory. I cannot remember whether there were any other applicants for the post but I was offered it and, furthermore, Donald Longmore generously decided that I should be paid as a senior registrar, which was a significantly higher salary than I had expected!

Despite some advice to the contrary, I accepted the post. Although even renal transplantation was at a primitive stage at that time, I suspected that organ transplantation would prove to be the future of all forms of surgery,

including heart and lung surgery. I took up the post in July 1967 and immediately attended the First International Congress of the Transplantation Society in Paris, which gave me some necessary background information on what was happening in organ transplantation. I was particularly encouraged by a presentation by Norman Shumway of Stanford University in which he reviewed his group's experimental studies on heart transplantation and stated that they felt ready to begin a programme of clinical heart transplantation in the near future.

'...M H Cass and Brock, working in the Thoracic Surgical Research Unit at Guy's, were the first to describe the technique of orthotopic heart transplantation...'

I then returned to London, where Donald Longmore had set up a research laboratory in the basement at the Royal Veterinary College in Camden Town and had got together a small team of technicians and research fellows to help with the project. One of the research fellows who joined us later was James Sekabunga, a Guy's graduate who hailed from Uganda. The group was already developing a technique for transplantation of the heart and both lungs in the dog which became the basis of the surgical procedure that is performed in patients today (2). As all who have worked in a cardiac surgical laboratory will know, the dog is a notoriously difficult animal model for studies involving cardiopulmonary bypass and aortic surgery. Our results were generally dismal, but we did some interesting studies on utilising the autoperfusing heart-lung preparation as a means of storing the heart for several hours (2 - 4) and, furthermore, explored the possibility of resuscitating the arrested (warm ischaemic) heart with a view to its use for transplantation (4, 5).

As part of my research project, I spent a good deal of time in the library of the Royal Society of Medicine in Wimpole Street reviewing what little was known about heart transplantation at that time. Many of the important research papers emanated from Stanford and were by Lower and Shumway and their colleagues. In 1959, however, M H Cass and Brock, working in the Thoracic Surgical Research Unit at Guy's, were the first to describe the technique of orthotopic heart transplantation in the dog which formed the basis for future clinical heart transplantation (6).

I was interested to learn that one attempt at human heart transplantation had already been made by Dr James Hardy in Mississippi in 1964, when a chimpanzee heart had been utilised in a desperate attempt to save an elderly

man who was rapidly dying from cardiac failure. The attempt was unsuccessful, mainly because the chimpanzee heart was too small to support the patient's circulation.

The First Human-to-Human Heart Transplant in Cape Town

My belief that transplantation would prove to be a major development in the future of heart surgery was supported - sooner than I or anyone else expected - by Professor Christian Barnard's performance of the first human-to human heart transplant in Cape Town on the night of December 2-3, 1967. This attempt, and the others that followed within the next 12-month period, gained enormous publicity and public attention.

'It may be difficult for those who do not personally remember those days to appreciate the excitement that this work generated...'

It may be difficult for those who do not personally remember those days to appreciate the excitement that this work generated, engendered partly by the dramatic nature of the surgical procedure but also, to some extent, by the relative youth and personality of Chris Barnard himself. He was (and is) a man with great charisma, and his youthful good looks and forthright statements to the press gained him much attention and lasting fame. Indeed, at the height of the public's interest in this topic, a survey identified him as the most recognised name in the world, known to more people than even the Pope, the Queen, or the President of the United States! In 1967, he was voted Time magazine's Man of the Year.

I had actually met Chris Barnard in 1965, more than two years before the first heart transplant, when, while spending a few weeks as a ship's surgeon after completing my house jobs at Guy's, I had visited Cape Town. Donald Ross - a medical school classmate and exact contemporary of Chris Barnard at the University of Cape Town - had suggested I visit Professor Barnard whilst in that most beautiful of cities. Barnard was extremely courteous and friendly, took me on a ward round, and also showed me the work going on in his research laboratory. I can remember Chris pointing out a patient to me and saying that what he needed was a new heart. Although I politely agreed, I thought this possibility so far in the future as not to be worth considering. At that time, it seemed to me to be in the realm of science fiction! In retrospect, it was clear that even in mid-1965 Chris Barnard had been planning this step forward.

Although Chris Barnard's first heart transplant was not a success, the patient dying after 18 days from a fungal pneumonia, his second patient, a dental surgeon named Philip Blaiberg (who had trained at the Royal Dental Hospital in London, now amalgamated with Guy's Hospital Dental School), survived almost 20 months, and was the first heart transplant patient who recovered sufficiently to leave hospital and return to a relatively normal life-style.

This relative success spurred on many other groups worldwide to enter this surgical field. In almost all cases this was ill-advised as the centres involved, although experienced in cardiac surgery, had little or no background or interest in transplantation immunology. Predictably, a large number of the operative procedures were technically successful, but the patients died in the early postoperative period from rejection or infection.

'Not long after the first transplant in Cape Town, Chris Barnard visited London to take part in a television discussion about heart transplantation.'

One offshoot of Chris Barnard's early attempts at heart transplantation was that, from my extensive reading in the RSM Library, I quickly put together a paper reviewing the experimental development of heart transplantation which was immediately published by the British Medical Journal and for which I received more than 200 requests for reprints (7). To a very junior research fellow this was encouragement indeed.

Not long after the first transplant in Cape Town, Chris Barnard visited London to take part in a television discussion about heart transplantation. Donald Longmore had been invited to participate and he arranged for me to be in the audience. There was some criticism of Barnard's work by one or two in the audience, notably the television personality Malcolm Muggeridge, but generally the questions and comments were positive. Chris Barnard handled the criticisms with his usual incisive comments and sparkling personality.

Towards the end of the programme, from the front of the row of the audience Donald Longmore announced that we were preparing for a transplant of the heart and both lungs in the United Kingdom. At this moment, one of my research colleagues entered the set pushing a wheelchair in which sat a gentleman who indeed would have benefitted from such a procedure. This provided a dramatic finale to the programme, although personally I felt this announcement was rather premature in view of our relative lack of progress in the research laboratory. The patient never received a transplant and unfortunately died sometime later.

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David K C Cooper

to be continued

An Interview with Dr H Thomas

Committed to Medical Education

Dr Hywel Thomas is a well known figure around Guy's. He is Pre-clinical Dean of UMDS and Chairman of the BSc Committee. He is also a Senior Lecturer in the Biochemistry Department. He is an extremely dedicated man and has done much for the improvement of medical education at UMDS.

How old were you when you first decided to go into your particular field?

I was very interested in Biology and Chemistry at school. I attended Llanelli Grammar School and I naturally drifted towards the biological and chemical sciences. Biochemistry in those days was a relatively new subject, so I originally had intended to go into pharmacy. But at an interview at the University College of Cardiff, the Professor of Biochemistry suggested that I should look at his subject, which was just being started as a degree subject; so I decided at that stage, in the upper sixth, to go into biochemistry at University. It is something that I never regretted. I was very fortunate to get into a department which was recently established and which had a lot of very good teachers and it enabled me then to get a good grounding in this fundamental discipline.

What was life like as a student?

Being in a young department, there was a very lively social scene. We had good teaching, but we also had a very good active social life, for example, there was a rugby team in the department, and we got to know each other very well. Teaching was essentially lectures and tutorials, but in my third year we spent a great deal of time doing a project and that is what really got me interested in research and that is why I am still very keen that all our medical students who intercalate a BSc have an opportunity of doing a project.

I was awarded an MRC training scholarship and stayed on at Cardiff to do a PhD. My subject was the biochemistry of sulphur-containing amino acids

and at the end of that period I got a post-doctoral fellowship to stay on in Cardiff for a year. It then transpired that there was a vacancy in the department for a lectureship which I took for a year. After that, I looked around for jobs and saw that there was a post in St Thomas' which I applied for and got, then starting my long association with these hospitals and with UMDS.

What was your first job like?

St Thomas' in those days was a very small school. There were only sixty students in the pre- clinical school, and one got to know the students extremely well, so my role as someone responsible for teaching the first years was very quickly established. I also had a very active research programme and at that time I switched my interests from sulphur-containing amino acids to insulin and that then started a long association of working with this molecule. In particular, I was interested in seeing how insulin was handled by the kidney, and that has proved to be my main area of research.

When you first started, could you have seen yourself in the position that you are now in?

No, not at all. I was really set on becoming a good biochemist and my goals were really to develop my teaching skills. I was very interested in teaching biochemistry to medical students and also to pursue my research. I had no thoughts in this direction at that time.

How would you summarise your present job?

Well, my present job is difficult to summarise because it is a job that has developed all the time that I have been in the post. I was the first holder of this particular position. I am essentially responsible to the Principal for ensuring that the School's educational policies with regard to pre-clinical students are put into place. I am responsible for the pastoral care of students in the first and second year and for ensuring that research and teaching is conducted in the pre-clinical divisions, according to the School's policies. My other role is in staff development and training. Another hat which I wear is Chairman of the BSc Committee, so as you can see it is a very varied job and every day brings in new challenges, new problems and new solutions.

What does your work as being Chairman of BSc require you to do?

To encourage students to do the BSc, but also ensuring that they realise the commitment involved. The other aspect has been to try and raise money for financing the BSc and to encourage more departments to put on BSc courses.

What do you enjoy most about your job?

The best thing I think is the day-to-day contact with the students. Students really make a medical school. Obviously, interaction with staff is just as rewarding. The post revolves around three themes: education of medical students, pursuit of biomedical research and providing an environment where people are happy to work and study and which enables UMDS to live up, I hope, to its reputation as a very good medical school.

Has your job lived up to your expectations?

This is a post which is, as I said, extremely varied, although when I took on the job I had no concept of the changes which would be occurring in the University Sector, in the National Health Service and in medical education, as seen over the last few years. Since I took on the post the GMC has brought in new recommendations that has involved us trying a lot of very interesting changes to the curriculum. Audit has come, in as well as assessment of teaching and assessment of research. So it is difficult to say if the post has lived up to expectations. It is a completely different job to the one which I envisaged when I took it over for the first time.

What qualities do you need to be the Pre-Clinical Dean?

Well, first of all, one needs to be a good listener and to listen to what students and staff have to tell you. You need to have a good pair of antennae to know what is going on. You need an extremely thick skin because you are always bound to disappoint some if you are pleasing others. You need some fairly nifty footwork sometimes and above all, I think you need a sense of humour and a sense of tolerance.

Are there any ethical issues which have troubled you in your job?

Not so much ethical issues, but I am very conscious of the fact that part of my role as pre-clinical dean does involve disciplinary matters with students and it does worry me sometimes that there is a certain element in the school which is intent on making life difficult for other members of the student body. They represent a very small minority. But generally, I must say no, I have not come across any great ethical problems at all.

What do you think about the changes at Guy's with regards to the Health Service?

Well, I have to really speak from the point of view of the School. UMDS is an amalgamation of four existing institutions. The old St Thomas' Hospital Medical School, Guy's Hospital Medical and Dental Schools, the Royal Dental

School and St Johns Institute of Dermatology. The School now has been in existence for thirteen years and it has taken some time for everybody to work together. For the last five or six years, staff and students have been working very closely together. The two hospitals only really joined in one Trust a couple of years ago and I think that the pace of change within the Trust makes it hard for all those concerned. The School has had a long settling-in period whereas everything is happening very quickly in the Trust.The School feels that the disposition of clinical services really is a matter for the Trust and for the National Health Service, but we are very anxious that we can ensure that vertical integration can occur successfully on both sites. That means that there should be good clinical facilities remaining on both sites. As you know, we are negotiating to merge with King's and as a part of that plan, the Life and Basic Medical Sciences of King's are scheduled to be moved here. I think that in order that this works well, we need to ensure that there are good clinical facilities also on this site. We all wait now with great interest to see what the position is going to be with regard to the disposition of clinical services between Guy's and St Thomas'. Whatever they turn out to be, the School will have to respond to ensure that medical education, dental education and research is protected. There are going to be some very complex decisions coming in the next few months and we hope and pray that the Secretary of State will come to the right answer.

You mentioned vertical integration of the medical course and you yourself have had a very large role in organising the new curriculum. How do you feel about the vertical and horizontal integration of the medical course?

Let's start with horizontal integration. I think that this has been a great success, in that it makes sense to teach the basic medical sciences alongside each other in an integrated and interdisciplinary manner. It has also helped the teachers because staff from various departments have worked very closely together in planning and delivering these new courses, so I think that horizontal integration has been a great success.

Vertical integration means more clinical contact earlier in the course but it should also mean more basic medical sciences later in the course. I think we are probably alright on the first part, in that our students meet patients from week one. We have recently introduced this year a GP contact for the first year students as well as for the second years. We also have some very good clinical demonstrations occurring in the first two years. What we have to try to achieve is more teaching of the basic medical sciences later on in the course. This has started with some genetics and embryology being taught in the quartiles, but really we need to improve on that and I believe that this should

be a feature of a school like UMDS. If we can't have a vertical integrated course here where the hospital is right next to the medical school, no institution really can. This is something that we will have to do increasingly in the next few years.

It is great to know that you support that system because I think many students have really appreciated the new course. Is biochemistry a tough subject to teach?

I suppose it is because dealing with molecules, ions and atoms you are dealing with concepts. Things that you can't see but you can obviously demonstrate and because of that, students do find it difficult. Students also find it less immediately relevant than physiology, pharmacology and anatomy, to what they perceive to be medicine. But increasingly, you can't read the BMJ or the Lancet these days without seeing how great an impact molecular biology and biochemistry have had on medicine. Yes, it is a tough subject to teach, but I think the biochemistry department have very good staff and put tremendous effort into their teaching.

Would you say that you are a tough examiner when examining medical students?

I don't think so. I think all the teachers here are very fair. We have got a very high quality intake of students with some of the best A'Levels in the country and I don't think examiners set out to be tough, they set out to be fair. Ideally, no one should really fail our examinations. If they can get through A'Level, they should get through our examinations. Unfortunately, some students fail every year, but increasingly I have come to the conclusion that they fail really not on academic grounds but because of a lack of motivation, or they may have some personal problems. So I think it is better not to talk about examiners being tough. Our great concern is about those few students who fail our examinations and it is something that we are addressing.

You mention the intake of students and that we do have some very good students. What do you look for when interviewing and selecting students for medical school?

Well first of all, they have to have the academic potential to cope with the course. We are looking for students who are obviously highly motivated, are good communicators and increasingly, for students who are able to do more than just do well academically, but are able to contribute to the life of the school and be able to enhance their profession, ie students who have got lots of extra-curricular interests. But the main aim obviously is to select students who

are interested in medicine as a subject and profession. It is difficult to try and find all that out in a fifteen minute interview and looking at the UCAS form. The school is engaged on a long term project, supervised by Dr Phil Richardson, to try to determine whether there any other things that we should be looking for, eg psychometric tests, IQ tests, aptitude tests etc, and we look forward to seeing the results of those particular studies. It may help us then to select the right students. But by and large, I think we get it right.

You are a very busy person active in a range of different things. When you do have spare time, what do you like to do?

I am a keen gardener. I have a garden and an allotment and I have found working in the garden is a good way to get away and relax. I am a great rugby fan, so generally through the winter season I enjoy following rugby. I like travelling, listening to music and going to the theatre. So I have a very varied life, but my only exercise really is gardening. It is good to relax and keep fit, providing my back does not give up!

You said you enjoy travelling. Is there any particular country that you most enjoyed?

I go to France every year and I really love the country. Although it is just across the channel it is so different from Great Britain, quite another world. With the food, the wine and the weather, it is a good place to visit.

Do you have any strong beliefs?

Yes, I have got a good sense of what is right and what is wrong and I think that has obviously been fostered by a Christian upbringing. I am very much against any kind of injustice and I think it is important, particularly in the medical profession, that we foster the concept of equality and equal opportunities right from the very beginning. Everybody should have the same chance and nobody should be discriminated against.

Who or what has been the greatest influence during your life?

I don't think there has been any particular single individual but, I have been very fortunate, as I said earlier, in the teachers I had at University College in Cardiff, and in the colleagues that I have had, first of all at St Thomas' and then at Guy's. I think it's the interaction with these various diverse people that has really been the greatest influence.

What has been the most important lesson that you have learnt from life?

To ensure that one works well with colleagues and in this the important aspect really is good team work. One can't achieve anything these days on ones own. One has to be able to listen, consult, hopefully influence people and then come to a collective decision.

UMDS is a good example of that. It is a very happy medical school, we have got staff of all categories working extremely well together: non-clinical staff working well with clinicians, a very good administrative team, Registry, Finance and Personnel and they work very well together. The departments have got good academics and supportive staff and I believe UMDS is one of the happiest places one could work in. It deservedly has got a very good reputation for staff relations.

How would you describe yourself?

A middle-aged Welsh biochemist who is quite happy with his lot. I am very fortunate to be in a job which I enjoy doing, which brings lots of challenges, but also brings its rewards.

Have you fulfilled all your ambitions?

No certainly not. I would like to see UMDS take further this revolution in medical education. I think we are still very much a teacher-based institution and what we have to do in the next round of curriculum reform is to try and see whether we can put more responsibility on students, developing a more student led curriculum. That would probably take us down the road to either a problem solving course or an evidence-based course.

Some institutions in Holland and in Canada, in particular, and now in the United Kingdom have either been trying that approach or are about to introduce it. I think that is something we should consider in the next few years. But it is not going to be easy to achieve with two hundred students per year and the amalgamation with King's, with three hundred medical students per year, will make it even more difficult. It is the way forward rather than relying so heavily on lectures.

What is the achievement that you are most proud of?

Probably the introduction of the new curriculum. I think with all its faults and rough edges it has been a great step forward and has put us more or less in line with what the GMC recommendations require. I am also very pleased to have been Chairman of the BSc Committee at a time when we have introduced a number of new courses and when the number of students intercalating at BSc have risen from 25% to well over 50% in a few years. What

is also particularly gratifying is that as well as having one of the highest percentages of students who are taking the BSc in the United Kingdom, UMDS also probably supports more students financially to do a BSc. Students do not get a grant from the local authority for doing the BSc, but we have through various charities in the hospitals, in the School and outside, raised sufficient funds to support over 80% of our students. I think that UMDS ought to be very proud of that achievement.

Sunita Gossain

Psychosexuality

At Guy's from 1964-1994

Every new Clinical Professor brings to their post ideas about clinical priorities, teaching methods, and research plans. When I arrived at Guy's, as Professor of Psychiatry in 1974 I brought with me some of the excitement of the 'new sexuality' associated with the names of Masters and Johnson who had reported on their Californian physiological and treatment studies in 1966 and 1970. I was able to start a psychosexual clinic at Guy's in 1974. Before that, a clinic had been started in Oxford (by John Bancroft, now an extremely expert sexologist), and I had started one at St George's before moving to Guy's.

'...as Professor of Psychiatry in 1974 I brought with me some of the excitement of the 'new sexuality' associated with the names of Masters and Johnson '

We had realised from the outset that the 'M&J' methods could not simply be transposed to the UK and the NHS. After all, Masters and Johnson had treated couples resident in what sounded like a special kind of sexual greenhouse where therapeutic sexual activity was encouraged continuously for a whole fortnight. These methods clearly had to be modified for NHS conditions. In those early days few of us doing psychosexual work had any specific training and as in so many areas in Medicine 'worked it out as best as we could'. In fact, most of those working in the psychosexual work came to it from the also-by-then emerging behaviour therapy field with experience of the active treatment of phobias and obsessions in particular, and used the same general approaches with sexual problem patients.

It is hard to realise now what a 'sea-change' the planning of a sexual problems clinic meant in those early 1970s. Throughout my own training as a psychiatrist during the 1960s, at a prestigious postgraduate training institute, I was never invited to treat any patient with any sexual problem and I do not think anyone else did either, excepting only a small number of people trying to do research on the extremes of deviant sexuality, which then as now tended

to arouse mixed and often troubled emotions among any who knew of it. (It is worth adding that until 1967 the commonest reason for referral in psychiatric outpatient clinics which I attended was a search for an opinion which could allow a girl with an unwanted pregnancy to have a termination, only possible on medical grounds; this unhappy activity ceased totally on the day the 1967 Abortion Act came into force). So awareness of the possibility of actual treatment for sexual difficulties, following M&J, was a real excitement.

For the first decade at Guy's (1974-84), we received a steady stream of referrals of people who mostly complained of problems with the mechanism of sexual arousal and response, including premature ejaculation and erectile problems in men, and problems with sexual arousal and satisfaction in women. Most patients were relatively young and seemed to have psychological causes for their symptoms. We saw couples, mostly because they had been unable to consummate their marriage, often through vaginismus.

The picture has changed remarkably during the second decade, in three major ways, since about 1984. First, major developments in the understanding of mechanisms underpinning erection have established that physical factors contribute to erectile problems much more frequently than had been thought. (Not that problems are either physical or psychological; the question is how much of each kind of influence operates in a particular case). Therapeutic improvements have meant that understanding the pathogenesis of impotence is not of merely theoretical interest and should inform treatment which patients may find very helpful.

'Sadly, there has been a huge increase in violence in close relationships, predominantly but not exclusively by men on women...'

The second change in our clinical work in the last decade is in the proportion of people who come with what are much more relationship than purely sexual problems. There is overlap with marriage guidance (now called 'Relate') whose facilities are under enormous pressure. Sadly, there has been a huge increase in violence in close relationships, predominantly but not exclusively by men on women, with consequent separation or divorce. It has become important to try and direct therapeutic endeavour to the men whose interactive behaviour causes so many problems as well as to the woman who may present battered and frightened, while trying desperately to bring up children. Lest someone may think medical or psychiatric involvement in marital conflict hardly seems like the treatment of illness and therefore the right use of scarce

resources, it is worth commenting that having a close confiding relationship protects against important health problems including depression, and conversely that being brought up in a violent, deprived, and fragmented domestic environment makes it very hard for an individual not to experience a wide range of problems and to become a major user of health services in their turn.

The third, and most remarkable, change in psychosexual work between 1974-84 and 1984-94 has however been neither of the above trends, important though these are. Before about 1986 I had seen patients with what are now generally called 'paraphilias', including some paedophilic men, and men sexually aroused by dressing in female garments, exposing themselves, or other activities. But adults complaining of having been sexually abused in childhood by adults were almost unknown. The epidemic of adults troubled by sexually abusive experiences in childhood has been quite extraordinary. Nowadays, a history of early sexual abuse is often found in a whole range of circumstances, including anorexia nervosa, depression, and various neurotic disorders as well as sexual dysfunctions and relationship problems. Sometimes, patients feel that the climate is now such that they can disclose these memories of which they are only too well aware. Increased disclosure of this sort is not the really remarkable phenomenon in this field. What is striking is that adults who for years have not been able to recall these events become able to do so, typically in the context of some relevant stimulus such as a television programme or topic. A psychotherapist with whom I discussed this remarked that 'repression is a social process'; this was not what Freud meant when he coined the term 'repression' to refer to the individual's mental process whereby experiences were 'pushed down' into the unconscious to become inaccessible to conscious retrieval. It would seem that this process exemplifies the potent effects of television images.

'...a history of early sexual abuse is often found in a whole range of circumstances, including anorexia nervosa, depression, and various neurotic disorders as well as sexual dysfunctions and relationship problems.'

The acceptability of sexual clinics to patients has become wider in recent years. The age range has extended, and in the last two years we have seen more than 30 men aged over 65; and we see homosexual as well as heterosexual

couples. (Homosexual interest per se is in no sense itself any kind of disorder). Also, we are seeing an increasing number of people from ethnic minority groups, reminding us of the enormous influence of cultural and religious factors on sexual and relationship function. There is now good evidence that some degree of sexual difficulty is extremely common--sexual and/or relationship problems sufficient to warrant treatment, should this be available, have been identified in about 10% of General Practice attenders. There remain many inhibitions about disclosing problems in this area to doctors; the Agony Aunt of a paper like The Sun receives several thousand letters every week, many describing sexual and/or relationship difficulties.

Clinical practice developments over twenty years have paralleled in teaching changes. In the 1970s, the introduction of a course on sexuality and relationships into the preclinical course provoked mixed feelings, with the screening of instructional sexual films greeted with massive audiences of teachers as well as students. By the mid-1980s students invited us to focus more on relationships and the interest in films had almost disappeared; students explained that the process of normal sexual function was already familiar to them. No doubt sex education had improved and in many social groups, sexual knowledge had become more thoroughly taught and learned. It would, even so, be surprising if everyone entering Medical School nowadays was as knowledgeable about sexuality and relationships as they would like to be. This is a field where the content of teaching is likely to continue to need guidance from students themselves. In every generation social forces shape the expression of sexual urges and the ways in which close relationships may develop, be maintained and break down. In every generation the massive impact of sexual and relationship problems on health needs to be recognised by all health professionals.

'In every generation the massive impact of sexual and relationship problems on health needs to be recognised by all health professionals.'

J P Watson

The progression from Medical Student to House Officer

A Psychological Metamorphosis

The great majority of students qualify at the end of their medical course. Some falter at the final hurdle and delay their exit by six months. The prize for qualification is entry into the rank of house officer and this brings with it many differences from student life. One of the most important differences is that some money starts to come in and the overdraft that has unaccountably built up during the final student years begins to look a little less daunting. Another major difference is in the expectation of the rest of the clinical team. There are expectations of students, but failure to meet these responsibilities is rarely disastrous for anyone else. As a house officer there are expectations that need to be met to deliver safe and prompt care to patients and to allow the smooth working of the clinical team. The clinical medical course should be a progression towards these responsibilities.In the first year the priority is to learn how to function as a doctor; how to clerk patients, how to behave with patients and colleagues and how to acquire clinical knowledge. The second year consolidates this and brings in some other practical skills in communication, general practice, paediatrics and the excitement of delivering babies, the first real practical clinical task for many students. The third year was designed to allow the progression from student towards house officer.

'As a house officer there are expectations that need to be met to deliver safe and prompt care to patients and to allow the smooth working of the clinical team.'

The shadow house job in this final year will provide an opportunity to work with a house officer. If you have ever wondered what house officers eat for breakfast, how far they walk during the day and what they do when they

disappear in to the nurses' office this will be your chance to find out. It is one of the additions to the new curriculum although many firms did this in a less formal way in the past. The two week attachment has some element of student choice as the posts rotate around participating consultants at Guy's, St Thomas' and Lewisham. Each student will be attached to one house officer and will have no other duties at the time. They will follow the same working hours' pattern as the house officer attending the same rounds and meetings. We hope that this will provide an opportunity for a closer look at the activities of a house officer without undue stress. At the end of the two weeks the consultant and the house officer will together make an assessment of the student's performance in the attachment.

'House officers need a good portable filing system.'

Instructions to house officers are given out on ward rounds, treatments suggested and investigations requested and most of the work of making these happen lies with the house officer. House officers need to be organised and methodical. They need to be able to get on with people on the wards, in the laboratories, in administration, and they need to get on with them even when stretched for time. A little time spent being pleasant even when pressed can pay great dividends the next time you need something.

House officers need a good portable filing system. It is not possible to remember all the instructions, all the results to chase up, all the people to ring with patients scattered across four wards at different corners of the hospital. Time management is essential. You will need good organisation for business ward rounds and for theatre lists. It is difficult to produce an acceptable excuse for not telling anaesthetists who is on the list, not telling the nurses about preparation for an investigation or not sorting out medications for discharge.

'Time management is essential.'

One of the usual complaints of house officers has been that they are so busy that they do not have the chance to learn anything during their time. Many of them never open a medical book during their year except to look up a specific point in the British National Formulary or a handbook of emergency treatment. Nevertheless they are learning most of the time. As well as the consolidation of their medical knowledge they learn the skills of organisation, time management, team work and relationships mentioned above. They also learn some practical skills. Students becoming house officers usually know how to take blood, to put in an intravenous cannula and to take blood gases. If they

are lucky they will have been taught to drain a chest or do a lumbar puncture. As house officers they should have the chance to perfect these skills and to learn other practical techniques under supervision. One of the most dangerous failings of a student or a house officer is an inability to appreciate when you are out of your depth. Ploughing on with a practical technique or with patient management when you are not fully competent is potentially disastrous for you and for the patient. Learning to recognise your limits of competence is an important skill which will be needed throughout your career.

'Learning to recognise your limits of competence is an important skill which will be needed throughout your career.'

As well as learning these practical skills there is the opportunity for a little more intellectual interest. Thankfully it has been recognised, albeit belatedly, that house officers are not just lackeys to fill in forms and organise theatre lists, they have continuing educational needs. There are sessions devoted completely to house officer education when bleeps are handed over to staff of the postgraduate department. In addition jobs must be arranged to allow attendance at regular meetings whenever possible. Meetings such as the Wednesday staff round at Guy's should be a focal point of the week. It is unfortunate that the attendance of consultants and others does not always set the best example for their juniors.

Part of the training of a student must be a preparation for the house officer year but five to six years of training are not aimed at just one year of work. They should be a preparation for the learning that must go on throughout the working life of a doctor. This is essential, medicine will change dramatically over the next twenty years. Many of the skills necessary for most clinicians now were not taught when I was a student 25 years ago. For instance the skills of administration, time management, teaching, computer skills; none of these was really touched on but they take up 50% of my time.

The most important things you can learn during your student time and take in to your house officer period is an enjoyment of medicine. It is a privilege as well as an intellectual pleasure to be able to practise medicine and look after people who are sick and vulnerable. It is a great opportunity to work in a team of like-minded people pursuing the same goal. Try to learn to get fun out of medicine as a student. It is the best lesson to take on to your house officer year.

John Rees

General Practice or Hospital Medicine?

A Student's View

Some of us out there may have definite plans for the speciality we want for our future. However, for those of us who are still non-committal in deciding whether we want to become Physicians, Surgeons, GP's, miscellaneous, or general layabouts, Medicine is a baffling hotch-potch. It is never too early to start thinking about where you are headed, believe me all your friends are one step ahead of you.

'Medicine is a baffling hotch-potch. It is never too early to start thinking about where you are headed...'

General Practice or Hospital Medicine? Of course one's aspirations are going to fashion one's ideas on the direction they choose. General Practice is often seen as a get out clause by students, in that you're no longer held *so tightly* by the shackles of the hierarchy. There are no consultants to rebuff you and no humungus hours to get through yet this does not mean that the pressures are any less. Of course you may be the type of person who wants the prestige of being a consultant and having immense power as the head of a team. At present junior doctors slave a maximum 72 hours a week *according to the government*. Probably by the time we qualify this will be shortened to 56, but many of us may be right to question whether this will just mean a *maximum 56 hours of pay*, the actual number of hours *done without pay* may increase. Scepticism is high among soon-to-be doctors. Regardless of whether we become GP's or hospital medics, for the first few years most of us will have to put up with these hours; it is several years down the road that the discrepancy in hours between primary and secondary care becomes noticeable. On call in London is 1 night in 4 for many and so one is destined to a good many sleepless nights in the hospital medicine route (this does vary between specialities).

On the other hand, as a GP you are free to govern largely by yourself in what is widely termed as a 9 to 5 job. Yes, you have the odd on-call to do but this is

governed by the number of partners in a practice and the use of deputising services in which a locum is paid by a GP surgery to do night calls. For example, five partners in a practice may mean a 1 in 5 if no deputising services are used. Not bad considering each call out is currently worth £45 from the NHS and on the other hand hospital doctors are paid half for any overtime.

This brings me onto family life. Seems far away if you are 19 years old and still having fun as a fresher, but we qualify at the approximate age of 23-24 years. In the early part of the next decade most of us will be looking to start families of our own. The type of medicine you are in has far reaching implications on this essential aspect of life. If you have the faintest ambition to reach consultantship then you will need to be competitive to some degree, and if you are female then it is well rumoured that the route to the top is even harder. Potential women-consultants may have to put off having a child until they have reached a certain rung on the ladder; pregnancy shouldn't have any consequences on promotion but this is never an absolute certainty. For those who marry out of the profession it can be hard to devote as much time as you would like to your partners and children if you are doing a 1 in 4 rotation. Also it sometimes becomes necessary to look for a job away from your home base and this can mean that your family will have to move with you. It is not easy to make an informed choice on what is for you. If you start a family early on, there has to be a balance between home life and career and this may compromise that necessary competitive edge. Is medicine your life or do you want a life outside medicine?

Is medicine your life or do you want a life outside medicine?

Once you have decided to become a GP the quickest route is to apply for a place on a GP scheme. These schemes last 3 years. One year is spent in a general practice (this can be split into two blocks of six months) and there are four blocks of six months in which there is some aspect of choice. Some examples being Paediatrics, Obstetrics & Gynaecology, General Medicine, Geriatric Medicine, etc. On qualification you can find a practice and immediately become a partner. This may involve buying into a practice which means that you become joint owner of the premises. If you cannot come up with a lump sum, money towards your share of the premises is deducted from your salary annually. This may be the type of practice you want to stay in for the rest of your life in which case there is no further fighting for promotion, just a comfortable salary and familiarity. If you decide after a few years to move to a nice suburb with a higher general practice income there is nothing to stop

you doing that except the usual barrage of interviews and scrutiny of your CV. The interviews are different in that they are likely to be more informal with the onus on your suitability as a partner and whether you will fit into the practice. It is fairly important that the partners like each other since they work together under more confined circumstances and have to make decisions about the practice services together.

This brings me onto the money aspect. If you are money-minded then the best thing to do is shop around for a lucrative practice on qualification. There is nothing to say that the partners will like you and the competition may be tough. Often there is a six month probationary period spent in a new practice after which the final decision is made. A new partner will take approximately three years to *'come on a parity'*, that is earn as much as the other partners. There is of course some payment made for seniority but this is only a few thousand a year extra. The average quoted net GP income is £41 000 with a variation of between £35 000 to £100 000. This depends on the number of patients on the list and by the sort of services a practice offers. For example if a practice provides obstetric services and does minor surgery they stand to earn more. There are extra fees for contraceptive services, teaching medical students etc. A rural practice which prescribes its own medicine earns more. Therefore to some degree the harder you work the more you can earn.

So in plain English this means that if you qualify at the age of 23 years then you will do a one year housemanship and a three year GP course before you become a GP at the age of 27 years. In your first year as a fully fledged GP you will earn just over half of what the other partners earn and by your third year as a partner you will be on a parity. Therefore by the age of about 30 you should be earning an average £40 000 to £50 000 income. This therefore is fairly big money at a relatively early age.

In comparison a house officer earns £14 000 basic pay. A senior house officer earns £17 000 to £22 000 basic. A registrar earns £19 000 to £23 000. A senior registar earns between £22 000 to £28 000. A consultant on the NHS earns £40 000 to £50 000 and with private work this may go to over £100 000. A doctor on average reaches consultantship at age 35 to 40 years. If money is your game then you must take your pick but both routes, hospital or community, are lucrative. MONEY ISN'T EVERYTHING.

Both career routes have their own attractions and are viewed in a different light by us all. In the end it may be our love for a speciality which tips the balance but it is true to say that for many of us confusion will still reign supreme as we enter the rest of our lives.

Sanjay Varma

Surgical Case Histories

This book is rather like the author. How many students have rushed past Harold Ellis in some corridor at Guy's (or Westminster or Cambridge, for that matter) on their way to their first ever session in the DR without even noticing the unassuming Prof? In a way, this book is similar: **Surgical Cases Histories From The Past (Harold Ellis, Royal Society Of Medicine Press ISBN 1-85315-222-6)** looks like another addition to your vulnerable consulting room shelves. It would be easy to miss this knowledgeable and interesting collection. In these days of marketing and design it seems that there just isn't time to read books with beige covers. Well, I had to. On a particularly long tube journey I began: I was surprised, I really enjoyed this book.

I began with something easy and gory: the first mitral transauricular valvotomy by the wonderfully named Sir Henry Sessions Souttar. If you intend being a famous surgeon you would do well to change your name to Sir Barnaby Arbuthnot Snell Dehydrogenase Smythe. I followed up my first historical valvotomy with a minute by minute, and year by year, account of the first ever laparotomy. This was by McDowell as far back as 1809 and in Kentucky! Feeling good with these under my belt (gown, surely?) I proceeded to the beginning of neurosurgery with Macewen and the first excision of an intracranial tumour. These cases come from the Major Advances section, which is followed by sections on surgery at war, emergencies and disasters and the surgeon at work.

If you have ever wondered why the contents of a scrub nurse's trolley had such ridiculous names, or whom the anatomical landmarks of the body were named after then this book has your answers. All the big names in surgery are present here including Langenbuch, Bilroth, Cushing and Grey Turner. Not missing the point either, with McBurney and Murphy present. Each case is presented with an introduction to the case and the surrounding history and the original published record. Cases are relatively short and contain good clinical details, clear even through some of more quirky historical practice which itself is interesting.

A good book--get it now and impress consultants with your knowledge of the origins of modern surgery...you'll be able to ask the questions, starting with the date of the first laparotomy!

Richard Littlewood

What Do You Eat?

What we eat has a lot to do with how we function. Nurses are in an ideal position to advise on the best form of diet to keep healthy: though we may not be fully trained in dietetics, we are often a point of contact for patients and clients who are looking for advice.

Once consumption of certain foods is restricted, then it is reckoned that a risk of heart disease will be reduced. Since heart disease is a major cause of early death in this country, it is appropriate that nurses, who have a great deal to do with those who suffer from this disorder, should help them to avoid becoming patients in the first place. And, are nurses aware of the importance of keeping an eye on their own diets?

Since Project 2000 has come onto the scene as a training process for nursing, there has been a concentration on nurses taking the lead in prevention - meeting the public - not just fulfilling the role of administering treatment either in the hospital or in the community.

The standard areas which are taken regard of aim to keep weight at a healthy level by exercise, relaxation and checking on such features as blood pressure, cholesterol, reduction of alcohol intake and total abstinence from smoking.

Fat, salt, sugar and fibre are the main targets: the first three to be reduced and the last increased.

Personally, I favour a vegetarian diet, though this poses problems. Firstly, a lacto-vegetarian regime which includes dairy produce and eggs, may include high levels of fat. To achieve a satisfactory level of polyunsaturated fat ingestion, may mean making the leap, to become vegan, thus avoiding all animal produce. Secondly, and in fairness, the clamour there has recently been about the export of veal calves, could be attributed to the increased consumption, of dairy produce. And this, in turn, may be due to the rising popularity of lacto-vegetarianism. So, in avoiding meat eating, we vegetarians have become culprits in the veal argument. This is not a situation we would have wished. I am happy to note that it is the inhabitants of a town near where I undertook my early nurse training, at Shoreham in Sussex, who have made a loud protest against the export of these live calves.

However, I have recently encountered a further argument that most, if not all, the animals which humans consume, are unaware of impending death. They also do not have the level of cogitation to know about death in the way that humans do, but since like us, they all die eventually, then provided they are killed humanely, we need not worry about it. I am not

at all convinced by this riposte, and even though advance knowledge of death may not be something of which animals other than humans are aware, I feel sure that once within the sight and sound of an abattoir, most animals for slaughter are aware of their fate.

Vegetarianism is not a new dietary phenomenon: I have recently browsed through a history of vetegarianism entitled 'The Heretic's Feast' by Colin Spencer. It points to the difference, which seems very little, between one early vegetarian, Pythagoras, and Dr Bircher-Benner - a food reformer of more recent date.

Incidentally it lays the lie that a vegan diet, with food of no animal organ, is deficient of Vitamin B12.

Moving away from considering of animals in our dietary requirements, to diets that are proposed for the obese, one enters a different world. There are many -some very costly - dietary products on the market which are sold for weight-loss. A private member's bill by one MP has sought to outlaw most of these as useless. I have no expert knowledge on this subject.

But I expect many nurses are often confronted by clients or patients seeking advice about healthier living, and specifically how to lose weight. It is our duty to give proper medical advice, and in the absence of this to be able to refer patients to those who have this knowledge. Dietitians are available, but it has increasingly become the role of the nurse to be a point of reference.

Nurses should always look at their own practice. Since the promotion of healthy lifestyles should be an integral part of a nurses job, it is important that they lead by example, and follow the advice they urge upon others.

Denis Cobell

Patrick Raymond Montgomery FRCP

Patrick Montgomery died suddenly on Monday, 13 February 1995 at his home in Winchester. He qualified in 1945 and later worked for many years in the Skin Department at Guy's before becoming consultant dermatologist to the Wessex Region. He was universally loved and cherished as a singular and unique person who enhanced the lives of his many friends, colleagues and all his family connections. A memorial service will be held in due course.

GW Scott

Wolf George Tillman MD FRCP

Wolf Tillman died on 3 January 1995 in Alderney in his eighty-third year. He qualified at Guy's in 1940 and subsequently became consultant dermatologist to the Woolwich Group of Hospitals, retiring to Alderney in 1972. His connections with Guy's men and women were legion and he was held in enormous respect and affection as a great Guy's man. A memorial service will be held at St George's Church, West Grinstead on Friday, 21 April 1995 at 2.30 pm.

GW Scott

Rugby

Guy's Hospital 150th Season Celebration Tour to South Africa July 1994

The fourth event of the Guy's sesquicentenary season was the tour to South Africa. This followed the Celebration Day in October, the match at the origin of Rugby School in November and the celebration dinner at the Waldorf in April. Rather ambitiously, an itinerary had been planned for two sides and much activity had gone into selecting a side, training and fund raising. With the help of Guy's Hospital RFC Supporters' Club, a total of about £12,000 was raised in sponsorship which reduced the cost of the tour to the individual players, particularly students, by approximately 30%. Some of the selected players were injured before the tour but still came, and thus a party of 45 players and 5 officials left London on the last day of June. The officials included the Club President and his wife, Professor and Dr Challacombe and our ex-President, Mr T L T Lewis and his wife. T L T had been brought up in South Africa and was looking forward to renewing contact with friends and relatives.

Unfortunately, the pick-up point for the team was outside the Miller Pub which was proving all too much of an attraction and it took considerably longer than expected to get all the players on to the bus at the same time. Nevertheless, the bus arrived at Terminal 1 in good time for the flight to South Africa. The planned itinerary was for five matches for both the first and second teams to be played in Johannesburg, then near Durban, in Port Elizabeth and the final two matches in Cape Town. In between, a visit to a game reserve and boat trip on an inland lake had been organised. An eventful flight was made more interesting by a psychological battle between a rather unfriendly South African Airways hostess and the party who were feeling uninhibited, and won. On arrival at Johannesburg a minor hitch was revealed when the University of Witswaterrand claimed that they had been expecting only to billet one team, and this resulted in some delays while further volunteers were sought. Match reports appear elsewhere, but the Guy's players had a wonderful time at Johannesburg and were well looked after by their hosts. The pattern of the tour had been to alternate billeting and stays in hotels, and this proved a very successful mix. In spite of social activities, the teams gave an excellent performance against much bigger and stronger opposition, even though they lost both games. We found out that a combined Irish Universities team were touring South Africa at the same time, and three of our fixtures were against the same opposition, and they also lost to Wits.

Minus two players and three lots of kit, we then moved to Durban. We then left by coach to a place called Kokstad in the mountains some four hours south of Durban and to which we travelled by coach. Kokstad turned out to be an amazingly hospitable town, and is situated between the two halves of the Transkei. We had magnificent hospitality, and the hosts laid on barbecues, a mountain climb and lots of beer and parties. They organised for the local golf club to be more or less made over to Guy's for the day, and even lent some of the officials a car. The temperature was much colder than expected, dropping down to -10 degrees at night with a vigorous frost, and the teams were surprised that on climbing Mount Currie, the last 200 feet were climbing in snow. All but 15 of the party missed this particular aspect. Amazingly, the Guy's team played not the local club but Southern Natal, and both teams lost in spite of another good performance. Our hosts laid on an enormous barbecue and roasted five sheep and organised parties until the small hours. This was the first time the town had ever hosted a touring side, and our visit was much appreciated with comment in the local press for several days running.

After an early start, the party moved on via Durban and the beach to a game reserve called Hliuhluwe where members of the party were introduced to big game. A night drive with searchlights was a novel way of seeing animals, but the main safari was next day where some spectacular sights, including a herd of 60 elephants and lots of hippos, giraffe, and rhinos, which are bred there, and crocodiles were seen. A boat trip on an inland lake also revealed lots of hippo and crocs as well as Goliath herons, though not all these sights were fully appreciated. The manager of the hotel at Shlshlewe will remember the Guy's party for some time, since he revealed that this was the only party in his time of management to drink the hotel dry of beer. A visit to a Zulu encampment with a meal under the stars was a spectacular and enjoyable event. It was at this evening that the second aardvark was discovered.

The tour moved on to Port Elizabeth where a civic reception had been laid on by the mayor. He had been in office for only three weeks and was the first black mayor in South Africa. Speeches and gifts were exchanged and we were honoured that such efforts had been made on our behalf. The party was put up at Jeffrey's Bay, a surfing resort some 100 kilometres South of Port Elizabeth. This is Afrikaaner heartland it was apparent that attitudes were not as relaxed as elsewhere in spite of great efforts at integration by the President of the Patensie Club. A breakfast reception with the mayor of Jeffrey's Bay was most enjoyable and enabled the team

to meet the local press, who were extremely interested and pleased that a touring side should come this far. Both teams, nevertheless, lost narrowly to Patensie in spite of excellent performances. One interesting point that the same referee who refereed the infamous match between England and Eastern Province refereed this game, though it was perhaps not his fault that Guy's suffered four injuries during the match. The last part of the tour was in Cape Town and all the party arrived safely, though it is doubtful whether two members will remember their journey. The team were put up in the Holiday Inn in Cape Town, and quickly discovered the entertainment of the new waterfront, and particularly the sports cafe. We had the interesting experience of visiting the University of Western Cape and playing under floodlights a local side called Tygerberg who were the local area champions of the 'coloured' league. The second team played Belleville South, the runners up in this league, and really far too strong a fixture, though Guy's played gallantly against an an extremely fast moving side. Both Tygerberg and Belleville South were immensely pleased to play their first ever touring side, and were extremely gracious. In spite of playing in the magnificent stadium at UWC, the individual players were clearly very poor, and thus not able to provide the usual hospitality. It was a very good experience for Guy's to play such sides which clearly helped towards acceptance and integration, and were in themselves very enjoyable.

For the last two days, Guy's were hosted by the University of Cape Town and players put up at a local school, Rondebosch Boy's High School. Although efficient in keeping the players together, this form of billeting did not allow us to meet players from UCT, and we missed this interchange. Indeed, we were planning to play matches on the Saturday morning and leave for the airport in the afternoon. The University of Cape Town is an extremely strong Club playing in the National League and although we were leading at half time, we let in several tries in the end to record our heaviest defeat of the tour. Unfortunately for us, there was a Currie Cup game in the afternoon which meant the rapid and surprising disappearance of UCT Club players and officials, leaving the Guy's players alone in the UCT bar buying their own beer, and certainly disappointment at the lack of any hospitality. At least this meant that for a first time on tour the team was early to arrive at an airport for an uneventful flight home.

Reflections on the tour suggest that this was one of the most ambitious tours undertaken by Guy's Hospital RFC but one which came at a most appropriate time in our and South Africa's history, and will certainly

have helped to enhance international and racial relationships. In all aspects apart from the actual results, it was a most successful tour, one which the participants will remember for a long time and one which did justice to the history of this great Club. Players would want to pay a special tribute to the Chairman of the 150th Anniversary planning committee, Mr T L T Lewis, and his successors as Presidents of Guy's Hospital RFC, Dr T Gibson and Professor S Challacombe for all the organisation they put in to make this tour and, indeed, all the year's events possible.

Guy's South African Tour
Guy's RFC vs Patensie
9th July 1994

Second team versus Patensie 2nd team. Patensie is in the heart of the citrus fruit area of the Eastern Province of South Africa. Eastern Province has two great claims to fame recently; the first is, of course, the refereeing on the recent England Tour, and the second that of Patensie Rugby who were featured in a recent documentary for their efforts in espousing the cause of integrated rugby, something which at Guy's we have taken for granted, but which is novel in the new South Africa. The Patensie pitch was set in the foothills of the mountains which looked magnificent with barely a house in sight. Guy's got off to a cracking start, but their three days on safari and lack of match practice showed. An early drive into the Patensie half led to a penalty, as our famous Llanelli move was misread and the ball dropped two yards from the line.

However, after Guy's were 3-0 down after a penalty for offside our initial impression of Eastern Province refereeing was not enhanced when, after a good heel, the Patensie back row were allowed to steal the ball in front of the scrum half.

Guy's were playing as if they had had a few too many drinks, and a sluggish first half performance left them 17-3 down at half time with two good tries from Patensie resulting from pressure in the centre and an enormous fly half. In the second half Guy's were playing with the wind, and showed signs of waking up and, after a fine series of movements, Bevan went over in the corner converted by Gush to leave the score 17-10. That remained the final score and, in contrast to the previous two games where Guy's had played magnificently and lost, they would leave the pitch knowing this was the game they could have won easily if they had played to the same standard.

1st XV versus Patensie

The fears were that the first XV would suffer the same malaise, but an early off-the ball thump from the Patensie number four woke the side up, they immediately got into their

stride and took play close to the Patensie line and almost scored. They were playing with an international referee and some of the refereeing interpretations were a little easier than in the second XV game. The scrums looked solid but the passing along the line once again lacked fluency. Undoubtedly the man of the match was B Challacombe who put in a series of devastating tackles in the middle of the field, no doubt benefiting from having watched the video of Mickey Skinner's greatest hits. This was a good display by Guy's but from the dominant position in the first half, where 5 were taken against the head, the loss of both the tight head and the hooker as well as two other injuries upset the side and we began to lose our own ball and eventually Patensie crossed in the corner to make what proved to be the winning score at 5-0.

Guy's 2nds vs Belleville South 13th July 1994

Belleville South is a suburb of Cape Town close to the University of Western Cape. They are largely a Cape coloured side and area champions, a formidable team for the 2nd XV to take on. Under the floodlights of the superb facilities at the University of the Western Cape, Guy's drew first blood with an early penalty by Gush. It was clear that the Belleville South team were going to run the ball from anywhere on the pitch and, after a drive up the field, Guy's were penalised and the score equalised at 3 all. However, Guy's showed that they were also capable of the running game, and a magnificent blind side break led to the opening try by Graham Bevan and a score of 8-3. A magnificent try from Belleville South with the ball passing through virtually all fifteen pairs of hands took then into the lead at 10-8. Somewhat frustratingly for the considerable crowd of spectators, Guy's were electing to chip and kick rather than run the ball wide, but too many touches were being missed, and the impression was of far too many mistakes. Nevertheless, it was an exciting contest. Another good handling move by Belleville South playing at real speed along the backs led to a try under the posts and a score of 17-11. A further try under the posts made the score 24-11. In the end, the speed of the Belleville side was impressive, and really was a lesson to the Guy's side in the art of quick handling, and the final score was 31 points to 11.

Guy's 1st vs Tygerberg 13th July 1994

A magnificent match ensured with Guy's playing the Tygerberg side recently promoted to the first division in South African rugby. This was due to be a stern test, but from the outset the Guy's forwards played magnificently and won more than their fair share of the ball and secured possession with ease. Tygerberg, as in the

previous match, had fluent runners and good handling, but all the early pressure came from Guy's. Unfortunately a breakaway try by Tygerberg against the run of play left them in the lead. Guy's pressure led to the equalising score with a try by Ugo in the corner. Half time came with the score levelled at 5 all, but with Guy's and their supporters optimistic that a win was achievable. The forwards were playing magnificently as a unit, but were perplexed by some strange decisions by the referee, particularly after driving mauls allowing the opposition to come in from the wrong side. On two occasions when Guy's pushed their opponents back on the goal line, a penalty try was not awarded. By this time, the Guy's pack were playing magnificently, and eventually a penalty for offside was given against the Tygerberg forwards, converted by Davies to make the score 8-5. An unpleasant incident later where the Guy's hooker was deliberately kicked on the ground incensed the crowd, but the penalty was not converted. As Tygerberg backs broke out once again it was clear that they were dangerous going forward and that Guy's were going to have to work hard to hold on to their slender lead, but hold on they did to win a most exciting game 8 points to 5.

Guy's vs Uct Cape Town
16th July 1994

On the beautiful setting of the UCT ground underneath Table Mountain and over looking the bay, Guy's 2nds kicked off with the wind and immediately put UCT under pressure. However, a series of 5-yard scrums on the line produced no result and, from a sudden breakaway, UCT scored in the corner to make it 5-0. At this stage Guy's were looking really lethargic and certainly looking as if this was the last game of a heavy tour. However, the truth was that it was probably the social side of the tour that had taken its toll as opposed to the playing. Slick handling from the UCT side led to two further tries before an answering penalty from Gush.

The second half was played in much the same vein and two more tries, one converted, left the final score at UCT 27-Guy's 3. The UCT pack were far bigger than Guy's and, on this occasion, the Guy's players found them a little difficult to handle, particularly close to the scrum, where they burst through at great speed. However, there were some outstanding performance from Simon Russel and Richard Dales. Both showed an admirable commitment.

Ist XV vs UCT
16th July 1994

Again playing with the wind, Guy's first XV took off at a cracking

pace against a very powerful UCT team who were probably in the region of two stones a man heavier. Early on Guy's showed great commitment and tremendous tacking kept UCT at bay, and some wonderful passing almost led to a score by Gradilas with his deceptively fast running. UCT got an early score in the corner, but Guy's hit back with a penalty to make the score 5-3. At this stage the forwards were playing magnificently and winning good ball against a much heavier pack except in the lineouts. Then a quick break in the centre led to Ugo going over in the corner and the very satisfactory half-time score of Guy's leading 8 points to 5.

However, the second half was a different story. Guy's lost both centres through injury and the effort of continually stopping the large UCT players both forwards and backs began to tell. UCT then ran in five second half tries all of which were converted. Murphy scuttled over from the scrum half to give Guy's a further try and points and leave the final score at UCT 40 points to 15.

Disappointment in the result of the game was compounded when the players found that the changing rooms had been ransacked of valuables, especially money, and that with an impending Currie Cup game in nearby Newlands, that the UCT team and officials did not have time to provide any after-match hospitality to the players in terms of food and drink and even the speech of welcome by the UCT President was given in the absence of the Guy's President who was still getting changed after the running the touch.

Thus, the tour ended on a disappointing note. Nevertheless, it had been a magnificent experience for the players to have gone from from the enthusiastic hospitality at the University of Witswaterrand at Johannesburg to the amazing welcome at Kokstad in the mountains near Durban to the formal civic reception at Port Elizabeth and the experience of playing at the University of Western Cape, and the realisation of separate coloured leagues to the final matches at the University of Cape Town. All in all, this was a most memorable tour and worthy of the celebration of 150 years of Guy's Hospital Rugby.

Guy's 1st vs Esher
3rd December 1994
Lost 12-35

The Guy's Esher fixture is one of the oldest in London and the clubs have been playing virtually continuously for 40 years. Whilst Guy's welcomed back the Captain Tsolakides, and Llewellyn in the back row they were missing Barrio at second row and Jones in the centre, also Dai Evans at hooker was missing and was replaced by Roy Dixon. These days however Esher are in London 1 and Guy's in London 3. Guy's started

however as if Esher were in a league below rather than a league above and monopolised possession for the first 10 minutes, but without scoring. Esher had a pack which looked about twice as big as Guy's side and came back into the game with a series of powerful runs from the back row. However Guy's were playing exciting rugby and spinning the ball wide to the wings and almost scored in the right hand corner in a good move ably supported by the forwards. It was clear that the sheer size of the Esher forwards as well as their technique were going to be difficult to contain and after a strike against the head the Esher centre scored near the post to lead 7-0. However Guy's were not disheartened and some terrific handling by the backs with some clever interplay between Murphy and centres almost led to a try by Ugo in the corner. He was clearly obstructed, but the referee elected for a drop out.

Guy's then gave away a disappointing try when attempting to run it out of their own 22, the ball was dropped by Ugo and the opposing wing calmly dribbled over for a score. Guy's were unlucky to find themselves two scores down but it had really been penalised for lack of concentration but had more than matched Esher in terms of exciting rugby. Just before half time a penalty against Guy's for offside in a ruck was converted to leave the score at 17-0 to Esher.

Soon after the restart Esher scored a third and better try when diagonal miss move in the the centre brought a try to the posts then Guy's scored a splendid try after winning two successful scrums. Murphy scuttled around the blind side to score a try in the corner which was very nicely converted by Neal Davies. This was shortly followed by another Guy's try when Rowland chipped through and just beat the cover to touch down.

In the concluding part of the game the experience and power of the Esher side began to tell and they scored two more tries and a penalty to run out deserved winners by 35-12. Esher currently head London 1 and are making a determined try for promotion to the national league in which they hope to sit next year. Talk in the club-house afterwards was full of admiration for the style of Guy's play and the commitment of the side. Guy's clearly made many friends by their enthusiasm for the game and look forward to welcoming Esher to HOP in the next season. Esher were particularly impressed by the works of Guy's in the line-out where Bernard in his first game for the first XV and Challacombe at No 4. won a considerable amount of ball ably supported by props. Ryan played another storming game in the lose and the pack looked very comfortable against their bigger opponents in the

tight. In the backs the ball sped along the line with commendable speed although our tendency to cut back inside every now and then rather than kick for safety was penalised by a very fast Esher back row. In spite of the result the team should be pleased with their performance.

Team Tsolakides G, Dixon R, Hostert L, Challacombe B, Bernard, Ryan G, Llewellyn R, Murphy J, Davies N, Ugo Ekeowa Spencer J, Ronan G, Bevan G, Burt J.

SJC

Surrey Cup Match
Guy's 1st vs Dorking
Sunday, 18 December 1994
Won 22-10

In the centenary year Guy's made a hash of the Surrey Cup losing by default to Old Cranleighans. Perhaps we were over distracted by all the other events for the 150th season. This year however the dates are clear and in preparation for this match Guy's did not have a Saturday game and thus only a few pre-Christmas hangovers turned up at HOP fit and ready to play. Dorking are in London 1, two leagues above Guy's and it was clear that it was going to be a challenging game. Early rain at HOP left the pitch very wet but by the time of the game it was a reasonable day, overcast but a light wind, blowing down the pitch. Guy's set off at a cracking pace and after winning the first 3 rucks. Guy's went ahead with the penalty by Davies when Dorking were caught offside. The opposition were clearly a well organised team, able to apply pressure and this pressure was awarded with an equalising penalty.

Guy's were in fact a little fortunate not to concede further points as silly mistakes and finicky refereeing gave Dorking a succession of kicks at goal. Good work and breaks by the forwards were nullified by some slack work in the centre. Al Jones was not having one of his better days with a couple of stray kicks giving Dorking the ball and heart. Thus the impression of the remainder of the first half was a succession of Dorking attacks being repelled by sound defence, particularly by the back five of the scrum. Then on almost the only time they seriously threatened Guy's scored a magnificent try. Fine handling back and forth across the field eventually created sufficient space for Ugo to slip over in the corner. The half time score was 8-3.

Guy's really began to turn it on in the second half and for 20 minutes all the play was in the Dorking end of the field, with long kicks by Neil Davies who was having an outstanding game supported by fierce rucking from the forwards. This combination led to another Guy's try when a kick by Davies to the corner led to a line out worn by Barrio and with close support of all the forwards Ross

Llewellyn was driven over for the try converted by Davies and then a similar try when Barrio scored after a line-out the remainder of the game was a very exciting contest with Dorking mounting waves of attacks which floundered on the rock of Guy's defence. Magnificent tackling across the team kept the opposition at bay when on at least three occasions it seemed they must score. The referee awarded a series of penalties to Dorking for offences which were not immediately apparent to the spectators but which certainly led to an interesting and exciting game. Eventually Dorking did score a converted try but Guy's had yet another first division scalp to add to the list this season and were worthy winners at 22-10. It would have been nice to see more spectators at the game and no doubt the publicity machine will roll into action for the next round.

Team: G Tsolakides, D Evans, W Slim, B Challacombe, E Barrio, W Llewellyn, R Llewellyn, G Ryan, J Murphy, N Davies, A Jones, P Gush, G Bevan, J Burt, Ugo Ekeowa

SJC

Mana Kaha Karate Club

The Mana Kaha Karate Club has been, established at Guy's Hospital since August 1993, and currently has about 15 regular students. The club was born out of a need for intelligent self-defence instruction as well as the physical, mental and spiritual benefits of traditional karate.

Students training at the club study three main systems of fighting. The main system is tradition Okinawan Go-Ju Ryu Karate-do. This is an ancient form of karate developed on the battlefields of Okinawa - the birth place of karate. Go-Ju Ryu emphasises powerful punches, strikes and kicks directed at vital points as well as grappling and throwing. It is definitely a style for those wanting a no - nonsense approach to self-defence whilst encouraging the development of mental and spiritual strength.

Modern Sport Karate developed out of traditional Karate-do but specialises on those techniques which score at competition. It teaches explosive techniques and impeccable timing; an exciting sport with very real self-defence application.

Muay Thai (Thai Boxing) is an ancient and modern sport, popularised of late through the movie industry. It is a full contact martial art utilising very powerful punching, kidney, knees and elbow techniques to knock out an opponent. Anyone who has

watched Thai Boxing live or on television cannot help but be impressed with its power and fluidity.

Mana-Kaha Karate Club's instructor Sean Hayden is a highly accomplished martial artist having won numerous New Zealand, Oceana South Pacific, and British karate titles. He is also a former boxing and Thai Boxing champion and a qualified ringside judge in both. The current New Zealand Karate Team captain and a national coach, Sean is still very much into the competition 'scene'. Having worked as a professional 'bouncer' for the past eight years in night clubs and bars both in his native New Zealand and in London he brings a very realistic approach based on experience to his self-defence institution.

As a qualified and experience fitness instructor, Sean ensures that all classes, are conducted within the guidelines of safety and effective exercise.

Classes are run on Mondays from 5.30 pm - 7.00 pm and on Wednesdays from 6.00 pm to 7.30 p.m. All beginners and experienced students are very welcome. Any enquiries can be made to Sean on phone 0956-484-202/0181-891-8063 or Juling on 0171-237-5342.

Guy's and St Thomas' Historical Essay Prize 1995

The Lord Brock Memorial Trust, which is responsible for the Old St Thomas' Operating Theatre and Museum opposite Guy's Hospital, holds an annual competition for an historical essay on a medical subject. The prize for the 1995 competition is £300.

Any medical historical subject can be chosen, but there should preferrably be some connection with Guy's Hospital or St Thomas' Hospital or the Medical Schools.

Essays should be typed and of not more than 5000 words. Three copies should be submitted to the Clerk to the Special Trustees, Guy's Hospital, London SE1 9RT. Please print ESSAY COMPETITION on the back of the sealed envelope, together with your name, in order that entries can be registered before being passed to the Trustees. Publication will be encouraged.

The competition is open to anyone associated with Guy's and St Thomas' Hospitals or UMDS. The closing date is 30th September 1995.

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Guy's East Anglian Society

The 23rd Dinner of the Guy's East Anglian Society will be held on Saturday 22nd April 1995. The venue is Downing College Cambridge, the President being Lord Butterfield and the guest of honour Professor Cyril Chantler. Members will have received the application details by post but if there are any newcomers to East Anglian who would wish to be included in my database and come to this Dinner would they please get in touch with me. Early application is suggested as the Hall only seats 150 people.

B A Ross (Hon Secretary)
8 The Crescent
Chapelfield Rd
Norwich, Norfolk
NR2 1SA

Death

PLOWMAN, Robert David LDS, RCS Eng died 28th January 1995.

MADDISON, Bernard, MBE, MRCS, LRCP died 24th February 1995 suddenly in hospital.

Change of Address

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All feature articles should be approximately 1500 to 2500 words in length. Photographs and disks will be returned as soon as possible if requested. Authors are asked to supply a contact phone number in case of any queries that may arise.

Classified ads will be charged at £5 for 35 words and 15p per word thereafter. Changes of address will only be published if requested. There is no charge for this service, nor for annoucements of births, deaths and marriages.

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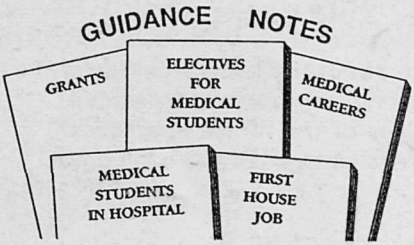

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Passim

The news of the reprieve for Guy's was greeted with widespread relief. It has shown that when an issue is worth fighting for and people can unite together that decisions can be altered. However the reprieve is only a temporary one and the closure of services at Guy's is still on the cards. We wait to see what the future holds for Guy's and other hospitals in the Capital.

Healthcare is changing in the United Kingdom. Some may say those who fight to keep institutions like Guy's open and functioning as a fully fledged hospital are afraid of change and hard decisions that need to be made; implying a rather myopic viewpoint on the part of the campaigners. This is a rather arrogant view, what is feared is that the wrong decisions are being made and that if they go ahead in the future the damage done to healthcare in London will be irreversible.

As spring begins to peek through the rather mild but wet winter the sun has on occasions decided to show itself on the hospital grounds and many have taken the brief opportunities to catch a few rays. It brings an almost fairground atmosphere to the area outside the medical school and Hunts House. This cannot be bad both for patients, hospital staff and students.

The final year students and others in various states along the academic ladder with impending exams, are wished the very best of success. If it is any consolation to those working for exams in the summer heat it's all worth it in the end . . . *isn't it!*

It is with great sadness that the death of a final year medical student, Miss Antonia Butler has to be reported. This has shocked and saddened the whole school. Our thoughts are with the family of Miss Butler.

Guy Blackburn

Dear sir,

I noticed in an issue in the autumn of 1994 a fulsome obituary of Guy Blackburn which did honour to a well-liked Guy's surgeon, although I believe he was trained as a student at St Bartholomew's Hospital.

The second paragraph, detailing some of the quotations ascribed to him, commented that he was noted as saying that 'The patient is always right'. This is a misquotation of Mr Selfridge who was reported as saying that 'the customer is always right'.

I was on his firm as a student in 1950. This quotation I did not hear from him on his teaching rounds; the short phrase seems far too simplistic for a man of Guy Blackburn's descriptive powers. I remember him saying on several occasions--a jewel of rhetoric--that 'all the most serious mistakes in medicine are made by those who fail to listen carefully enough to the responses of their patients'. I have treasured this saying throughout my professional life. I feel sure it has ensured that I have always taken a careful history and have interpreted patients' responses with care.

I am sorry to know that he had Parkinson's disease, an undeserved penalty at the end of a busy life.

Yours faithfully,

Howard S Reeve
Honorary Secretary
Guy's 52 Club

Clinical examination

Dear sir,

I recently overheard a story which I would like to share with the other readers.

A patient came into a busy A&E department in a North East London hospital. He had had a history of recurrent chest problems and the chest X-ray showed multiple lesions in both lungs. The patient had gone through a series of expensive and sometimes uncomfortable investigations over the past year. The diagnosis was still hazy and he was rather tentatively labelled with a diagnosis of sarcoidosis and told he did not have long to live.

The young casualty officer came to examine the patient and noticed a fullness in his neck. After a through examination he decided to order a biopsy of the mass he found.

Unfortunately for the patient the diagnosis came back as one of squamous cell carcinoma and the fullness in his neck was due to metastatic spread to the lymph nodes probably from the lungs.

The patient later asked to speak to the doctor and said that he knew he was going to die but he did not know from what he was dying. This gave the patient some comfort in the face of his adversity and he was very grateful to the casualty officer.

The point of this story is that regardless of the sophistication of investigative procedures, simple basic skills such as history taking and competent

clinical examination is always the cornerstone of medical practice. Needless to say the casualty officer was a Guy's man.

Yours faithfully,

A Johns

A Roof Over My Head

Dear Sir,

Finally! Finally, there is salvation for the debt ridden, homeless medical student. After months and months of deliberation the medical school has taken decisive steps to address the problem of restricted student accommodation. Proposals have been put forward for the construction of a new state-of-the-art building to house a large proportion of the student body in modern single-study bedrooms at a site very close to the Guy's Hospital campus. This is a significant step towards alleviating the current strain on rooms in the present hostels and will provide approximately an additional three hundred beds. Although, work is yet to begin, it is anticipated that the first occupants will take up residence by or before October of 1996. Many students may have already seen a prototype room when it was on display last year, but for those who have not, essentially these rooms will have *en-suite* facilities. The medical school is keen to gain the student body perspective on this issue before a definite choice on design is made. Plans are available for viewing at the medical school (please contact Mr Baker). A decision is to be made shortly, so I encourage as many students as possible to take this opportunity to air their views.

Yours faithfully,

Rikin Trivedi
Clinical Medical Student

Consultation--Health Commission recommendation

Public consultation by the Lambeth, Southwark and Lewisham Health Commission on hospital services in South East London ended formally on 17 February 1995.

The Commission has now considered the comments it received in writing and at a series of public meetings held over the last three months and has made recommendations to the regional Health Authority and Secretary of State. Final decisions will be made by the Secretary of State in April.

In its recommendations, the Health Commission supports the strategy proposed by the Trust to concentrate A&E and acute services at St Thomas' while developing an ambulatory care centre and elective surgical centre in Phase III at Guy's.

The Commission endorses proposals put forward by local hospital Trust to:

- expand A&E departments and essential backup services at St Thomas', King's College and Lewisham Hospitals and close the A&E unit at Guy's Hospital;
- bring together, mostly on the St Thomas' site, a range of services currently provided at both Guy's and St Thomas';
- develop Guy's as a new type of hospital specialising in treatment which does not require an overnight stay and as a centre for planned (non-emergency) in-patient treatment for patients on waiting lists.

One key element of the strategy, the closure of Guy's A&E and the associated transfer of emergency related services, has been deferred for 2 years until 31 December 1998 at the earliest to ensure that alternative services are in place and working effectively. The Commission also indicated three important conditions which had to be met before Guy's A&E Department could close:

- the other three departments, King's, Lewisham and St Thomas', must be shown to be capable of dealing with the increased work satisfactorily and at Patients' Charter standards;
- London Ambulance Service must beoperating at Patients' Charter standards;
- Primary Care in Bermondsey, Rotherhithe and Southwark must be improved to an acceptable level.

The Commission's chief executive, Martin Roberts, said: 'It is our unanimous view that the changes we have proposed are necessary and urgent but can only be achieved with additional funding from the Government over an extended timescale of six or seven years.'

Plans for running down Guy's were based on the need to save £16 million, but Mr Roberts said that between £18 million and £25 million would need to be spent on local community health services to take on the extra work. However he said the strategic decision eventually to close Guy's was 'absolutely right'.

Shadow Secretary of State for Health visits Guy's

The Shadow Secretary of State for Health, Margaret Beckett MP, and the Shadow Minister for Health, Nick Brown MP, made a short visit to Guy's on 23rd March. They toured Philip Harris House and there followed a short Press Conference afterwards. Mrs Beckett commented on the immense amount of activity that was going on at Guy's and was impressed by the facilities in Philip Harris House. When asked about the proposed changes at Guy's she said that there should be a moratorium on all further bed closures in London and further reassessment required. She also said services in London were being removed without any overall planning.

Statement Issued by the Save Guy's Campaign on 3.3.95

The Save Guy's Campaign welcomes the statement by the Lambeth, Southwark and Lewisham Health Commission which recognises some of the shortcomings in their plans for health care which were detailed in 'Looking to the Future'. We applaud the Commission for acceding to the needs of the community who have seen more and more of their local hospitals closed over the past twenty years with the promise that Guy's would always be there.

We are pleased that the Commission has emphasised that strict criteria MUST be fulfilled before the closure of Guy's acute services and the A&E department can take place. However, we have substantial reservations that these criteria can be met by 1999. In view of this and the undoubted changes that will happen in the local population, more widely across London and in medical practice, we feel that the services at Guy's should be maintained until such time as a further study shows that they are no longer needed. In the meantime, rationalisation of specialist services should proceed making full use of good quality buildings and sensitive to the need for easy public access.

Today marks the beginning of steady process of realisation that the previous statements by the Campaign have been accurate and that their vision of the future is both more realistic and clinically sensible. We are encouraged by the extent to which our arguments have now been recognised.

This news leads us to believe that the evidence in favour of Guy's staying as a hospital, and Guy's keeping its A&E department is gaining more support all the time. The supporters of Guy's Hospital have not yet won the day, but today's developments put us in good heart and make us more confident that the case for keeping Guy's will finally triumph.

Celebrity Football Match

The Save Guy's Campaign organised a Celebrity Football match on 12th March at Millwall Football Club. The afternoon went down very well and was attended by an enthusiastic crowd. The fixture was between 'The Show-biz Eleven' vs 'The Save Guy's All-Stars', captained by Mr Geoff Koffman.

Many famous personalities attended including Chris Evans, Eddie the Eagle, Steve McFadden, John Leslie and Marvin Berglass from Marvin's Magic.

Celebrity Football Match

NHS - Public Service or Commercial Venture?

Market Philosophy of the NHS

This is the text of an opening address by Professor Harry Keen at Southampton University Debating Union on 7 February 1995 proposing the motion:

'This house rejects the market philosophy of the NHS'.

The Motion was seconded by Ms Hannah Barton, President of Southampton University Students Union. It was opposed by Mr Iain Duncan Smith MP supported by Mr Donal Blaney, member of Southampton University Conservative Association.

I would like to thank the organisers of this important debate for doing me the honour of asking me to propose the Motion before this House. These are critical times for the future of an NHS which maintains its founding principles and social purpose but responds intelligently to changes in society and technology.

'I am greatly in favour of information-based decision making, whether in the planning of treatment or in the running of our health care system...'

In proposing this motion I would like first of all to make some points clear. I am not arguing against a better informed NHS with information systems giving us available, usable and reliable facts about needs and resources. On the contrary, I am greatly in favour of information-based decision making, whether in the planning of treatment or in the running of our health care system and I have had a substantial hand in developing both myself. Nor am I arguing against the planned targeting of resources towards individuals and problem areas of highest need priority. We need to do that at all levels,

with individuals, in institutions and localities, at regional and national levels. As Director of Medicine at Guy's I spent five years hard at work doing just that, long before the so called NHS reforms took matters out of clinically led hands and put them into financially driven hands.

I am, however, arguing against the imposition upon the NHS of a pseudo-commercial market structure, aimed primarily not at improved patient care but at finance-driven cost containment. The market structure imposed by the 1990 NHS Act introduced a monstrous new army of market bureaucrats into the NHS, probably around 20,000 of them, at a cost of billions of pounds diverted from patient care. The changes were imposed without mandate from the electorate, without consultation with the public or the professions and in the teeth of continuing opposition from both. They are of dubious democratic legitimacy.

'Market ideology has turned hospital against hospital and doctor against doctor.'

These costly and wasteful market reforms are dismembering what was an extremely cost-effective, if under-resourced, national collaborative health care system. The market ideology has turned hospital against hospital and doctor against doctor. All-powerful management, on high wages and short contracts, tells staff - doctors, nurses and all - that its first responsibility is now to the organisation; that to the patient comes lower down the list. There is now a new 'duty of fidelity' for the NHS staff, not to the patient but to the corporation.

Hospitals in this marketplace are funded on a competitive basis. Let us not fool ourselves, it is to the cheapest bidders that cash-strapped commissioning authorities give their contracts. Bart's and Guy's are not being closed down because they are not needed. They are being closed down because their prices are high and they cannot get contracts. Their prices are high because they now have to service an enormous 'capital debt', work in an expensive city centre and employ relatively costly experts and teams, to say nothing of the teaching, training and research 'baggages' that they carry. The market threatens the future of Bart's, Guy's and others not because they are so bad but because they are so good. The market is levelling the service down. The state of affairs has become so hazardous that the independent King's Fund stated last year that we now '..risk the disintegration of the system of health care in London with

detrimental consequences for the health of Londoners.' And many of our other major conurbations are in the same sorry state.

The market reforms were based on a misleading prospectus. They offered 'Greater patient freedom of choice'. Patients got the reverse. Before the market, any doctor could send any patient to any hospital. Now, patients have to go to their contract hospital whether they or their doctor wish it or not - unless a special contract can be negotiated. We were told that 'Money would follow patients', which beguiled many into thinking that famous hospitals would do well. In fact, money does not follow patients; patients follow contracts.

> ***'Equality of access for those with equal need, the principle of equity, has been seriously eroded by the market.'***

Equality of access for those with equal need, the principle of equity, has been seriously eroded by the market. Fund holding GPs can buy services for their patients wherever they wish, from NHS hospitals, from the private sector, even from each other. NHS Hospitals which run out of contract money before the year's end have to cease operations with their local resident population but can bring in 'paying' fund holder's patients or privately insured patients from wherever. Cash strapped financial management offers quick service and cut-price deals while locals wait on the waiting lists, or raise money to go privately. When the Secretary of State was asked how hospitals could avoid running out of money before the year's end she advised them to 'pace themselves'. Pace themselves? That is to make nine months work last a year!

This problem of 'excess capacity' carries more sinister implications than this silliness suggests. Trust Boards of Directors now increasingly try to make some more money to keep the hospital going by selling these 'excess services' to the private sector, to private insurers and so on. But for their money, the private sector demands and gets the best, the best access, the best opinions, the best operators - and no waiting! The taxpayer NHS patient gets what is left. Sales of NHS services to the private sector have trebled over the past two years and the rate is rising. Middle class people are worried now about the NHS and put private health insurance higher on their spending priorities. They may even feel some virtue in 'going private' and handing their NHS place over to those

less well able to pay. Increasingly, ability to pay is determining access even to NHS services.

Even more ominously, if NHS Trusts now need capital sums to expand, rebuild, re-equip, even to run a clinical service, they are obliged to seek funding from the private money market. Be sure that such private investors will insist on exercising control over local NHS operational policies to ensure the return on their investment. The private finance initiative in the NHS will make Trust management accountable to the merchant bankers and shareholders. Accessiblity of information to the public is enshrouded in commerical confidentiality.

I have touched on only a few of the ways in which the imposition of the market ideology and an increasingly commercialised culture is eroding our NHS, disintegrating it into thousands of little competing businesses operated by unaccountable quangos at vast transactional and bureaucratic cost. This down grades the tremendous spirit of commitment and co-operation which made the NHS a great public service in which so many of us have the privilege of working. I ask you all therefore, to indicate your support for the great social enterprise which is our National Health Service by voting for the Motion before this House.

The Motion was carried by a three to one majority.

An Interview with Professor Tak Lee

Professor of Allergy and Respiratory Medicine

Professor Tak Lee has recently been appointed as the Director of Thoracic Medicine at Guy's and St Thomas'. He has a prolific and remarkable career and is an asset to both hospitals.

Why did you choose medicine?

Our family had a lot of friends who were doctors and I was always interested in what they did. I wanted to be a doctor from an early age, so it wasn't a difficult choice for me.

How would you describe your life as a medical student?

It was crazy! I was at Cambridge initially and it was a very enjoyable three years in my life. There were so many things going on and plenty of interesting people to meet. I came to Guy's to do my clinical training because in those days the clinical school in Cambridge was not fully functional.

I had to work harder when I got here, but living in London was great fun. I suspect we did all the things that students do now, if not more.

What was your first day like as a house officer?

It was a frightening experience. I went from the textbook and supervised experience to actually having the responsibility of making the diagnosis and initiating treatment.

I still remember clearly one of the first patients I looked after. He had suffered a myocardial infarct and had multiple ventricular ectopics. In those days, Starling Ward was the Coronary Care Unit so he was moved up there.

I'd never looked after anyone that sick before. I called the registrar but he was busy seeing somebody else, so I was left to manage this patient. Fortunately, I must have done something right because he got better. That experience was very helpful to me; I realised that what you're taught by your teachers and what you learn on the ward is actually how things happen. That particular case gave me a confidence boost in treating patients. I knew then that what I had learnt was going to work.

What post-graduate training did you do?

I was a Junior Registrar (SHO) at Guy's and St Olave's Hospitals, during which time I passed my MRCP. Then, I went to the Brompton Hospital, where I was a Senior House Officer in Thoracic Medicine for six months, followed by a further six months at The National Hospital, Queen's Square doing neurology. After that, I came back to Guy's as a registrar in Respiratory and General Medicine. I spent two years at Guy's and New Cross Hospitals, before I did my MD research at the Brompton Hospital. I then went to Harvard for a couple of years on Medical Research Council and Royal College of Physicians Scholarships and returned to Guy's as a senior Registrar/Lecturer.

How would you summarise your job?

My job has changed: about six-to-seven years ago the National Asthma Campaign decided to celebrate its Jubilee year by establishing a Chair of Allergy and Allied Respiratory Disorders and applications for the Chair were invited. It was the only Chair of its kind in the country. There followed a national competition and I was appointed. The Department grew from a handful of individuals to a large team of approximately thirty-five investigators researching into the causes of asthma and allergies.

At the end of last year, Professor Ian Cameron, who led the Departments of Thoracic Medicine at Guy's and St Thomas', left UMDS to become the Provost of the University of Wales College of Medicine.

As a result, I was appointed to take on the extra responsibility of Respiratory Medicine. So currently my job is Professor of Allergy and Respiratory Medicine across Guy's and St Thomas'. There are approximately sixty people in this new department. So in the last few months my responsibilities have increased and I am a lot busier.

Why have you remained at Guy's?

I was offered a lot of interesting possibilities whilst I was working at Harvard. There were several reasons why I came back to Britain.

Firstly, I felt that my children would receive a better education and environment from being brought up here than in the United States. I also believed that my wife and I would be much happier living in Britain. I've never regretted returning and I'm sure we made the right decision. My son, in fact, was born in Boston and I have family in America so it could have been very easy for me to stay there.

Secondly, at the time I was finishing at Harvard, Professor Maurice Lessof (Professor of Medicine at Guy's) and Professor Tim Clark (Dean of UMDS) contacted me about the availability of a Lecturer's post at Guy's. It seemed to be the right move at the time, and indeed it was, because it gave me the opportunity to set up a department from scratch. It enabled me to develop some research ideas, which would have been much more difficult to do if I'd gone to an institution with an already established research programme. I've been very lucky, as the Medical School and Hospital have been very supportive of what we do.

Finally, the vision of a multidisciplinary science institute after our merger with King's is very attractive. If our academic activities can be integrated with a coherent clinical service, it would be very exciting indeed.

Why do you find research so appealing? Why asthma?

My research commitment takes up the largest percentage of my time. It's not that I find research necessarily more appealing than clinical medicine. I do both and I think they are equally important. But these days, it is wrong to believe that one can be very good at research and also spend an equal amount of time attending to patients - there aren't enough hours in the day to do that. So, one has to focus one's activities. I decided to concentrate on research because I felt that advances in medicine can only be made through research. There is no doubt that in recent years research in my field has substantially changed the way we manage patients with asthma.

The reason why asthma is so interesting to me is because it is very common and is one of the few diseases that can affect a person from a very young age into adulthood. It is increasing all over the world for reasons which are not clear. Biological, chemical and molecular state-of-the-art techniques are now

available to study the pathology and aetiology. In fact, Great Britain is a world leader in asthma research, mainly because research here has successfully married up basic and clinical science. In many countries, research work is being done on animals, but in Britain, we study our patients and we learn a great deal from them. We don't need to extrapolate from animal models into man. Asthma has no animal model, therefore you can only answer questions by studying the disease in man.

What research are you currently involved with?

Based on the cytokine profiles, there are two types of T-lymphocytes - TH1 and TH2. Recent research suggests there is over expression of TH2 cytokines in the lungs of patients with asthma. TH2 cytokines include IL4 and IL5: IL4 increases IgE production and is therefore important in allergy; IL5 is an important activator of eosinophils, which are believed to play a central role in asthma.

Dr Staynov with David Cousins in our group have recently discovered a new positive regulatory element in the promoter of TH2 cytokine genes. The hypothesis we are now testing is whether this element has a role to play in the pathogenesis of allergic diseases such as asthma.

There are many other things going on: Dr Kemeny and colleagues are very interested in how TH2 cells differentiate and how we can switch TH2 cells into TH1 cells - with the possibility of switching off asthma and allergies.

Dr Twort and colleagues are interested in smooth muscle biology. In asthma, the smooth muscle gets bigger and changes the geometry of the lung making it more irritable. If we can understand how to switch off the signals causing this hypertrophy, we can do something about asthma.

What are your views about the Government Reforms of the Health Service?

Well, I think the government has planned some major changes in the NHS based on information which is becoming increasingly viewed as suspect. The data in the Tomlinson Report, on which the Government Reforms are largely based, is now widely questioned. Professor Jarman and the King's Fund have conducted their own analyses and have come up with completely different answers. I really believe that the Government has to seriously reconsider its strategies. One is only too aware that the availability of beds is very limited

in London; A&E departments are straining to cope with the workload; and Intensive Care beds are highly pressurised.

What do you think about the changes at Guy's? How do they affect your department?

As far as academic activities are concerned, the present re-organisation of the department doesn't affect me too much. The medical schools have already been merged for a number of years. Because I work on both campuses, this involves more travelling and of course there are more people to look after. The research modules across the two campuses are fairly distinct although there are areas of close collaboration.

With respect to the relocation of clinical services on the two sites, it is really important that there is clinical coherence. It doesn't make any sense for one clinical speciality to be on one site and another speciality on the other if both are closely inter-dependant. Clinical coherence far outweighs all other considerations in my view. We need to think clearly about what is important, not for the next two to three years but for the next twenty to thirty years.

Do you have any views on the future role of the Philip Harris House?

I think that Philip Harris House is very important to us. It was designed originally as a State-of-the-Art Hospital, with wonderful facilities for clinical care and one floor was allocated to the Medical School for academic purposes. My department is moving to Philip Harris House, and as far as academic space is concerned, it will be a lifesaver for us. It is regrettable that the delay in opening Philip Harris House has affected some of the funding, especially from charitable sources.

What qualities do you think have helped you in your career?

That's a very difficult question for me to answer. I think, you have to be very determined and very focused on your goals. You have to know what you want, why you want them and then you have to plan the best way to achieve them. I do that all the time in my research because the funding is very limited, so you have to be focused on your objective. I think the other thing to realise is that you cannot work alone - you have to work as a team and one of the most important aspects of my job is to form a happy and cohesive team. People who try to go it alone often fail.

Who or what has been the greatest influence in your life?

I've had numerous mentors - too many to name here. They include past and present senior physicians at Guy's, Professor Dame Margaret Turner-Warwick and Professor Barry Kay at the Brompton, and Professor Frank Austen at Harvard. I respect them immensely. I've always learnt something useful from all my teachers and they have been very supportive.

What has been the most important lesson you have learnt from life?

I think one of the more important lessons is to strive for excellence and never be satisfied with the mediocre. You must be happy in what you do. You need the support of people around you; to be able to work as part of a team but also to maintain your individuality.

Would you recommend medicine to your children?

I think decisions on career choices have to be made by the person. If my children were interested in medicine I would do everything I could to help them. I'd explain the pros and the cons but ultimately the choice would be their own.

What has been your most embarrassing moment?

The most embarrassing moment I can remember (and there have been many) occurred whilst I was on elective, when I was assisting a surgeon. He had just finished the operation and was putting the plaster over the patient's abdomen. He held the plaster at one end and asked me to cut it. Unfortunately I cut his hand. I knew at that point surgery was not for me!

Have you fulfilled all your ambitions?

There are many things I'd still like to do. I work in five year stretches, because grants for research work tend to be for this period. So, I'll focus and try to achieve my goals during this time. One then has to await developments and plan again. I don't think it's possible to plan twenty to thirty years down the line.

Roopa Mehta

The First Heart Transplants in the United Kingdom, 1968-1980

The Role of Guy's Graduates

The second part of the Gazette feature on Heart Transplantation. The final part will be in a later issue.

The first Heart Transplant in the United Kingdom

At the National Heart Hospital interest grew to enter this field and, in the spring of 1968, Donald Ross and his surgical colleague, Keith Ross (no relation, and now Sir Keith) came to the Royal Veterinary College laboratory one Wednesday to carry out two orthotopic heart transplants in dogs. I carried out both of the organ retrievals. For the first case the heart was stored as an autoperfusing heart-lung preparation and in the second the heart was simply excised and immediately transferred to the recipient operating table. On the day, the second procedure was the more successful and the transplanted heart functioned well. However, as the experiment had been planned simply as a technical exercise, the dog was euthanized later that evening.

No mention was made of when a heart transplant might be attempted clinically, and my impression was that it was not imminent. I was therefore extremely surprised when I received a telephone call in the laboratory two days later from a member of the press asking me to confirm that a heart transplant was proceeding at the National Heart Hospital. As I had heard nothing to this effect, I denied the rumour. However, when a second call came through soon after, I checked with Mr Ross' staff at the hospital and found that indeed a transplant was planned.

Donald Longmore and one of the surgical registrars had gone to another London Hospital (Guy's, if my memory serves me correctly) to assess a potential donor, and the plan was to transfer the donor by ambulance to the operating room of the Heart Hospital where the heart would be excised after the discontinuation of ventilation and immediately transplanted into the selected recipient.

Naturally enough, as a member of the research group, I was irritated that I had not been privy to these plans, although I understood the need to keep them as secret as possible to try to prevent a leak to the press. I immediately drove to the hospital to watch the surgical procedure. The security there, aimed at keeping out the press was considerable. No one except the members of the surgical team was being allowed into the operating room, both from fear of the risk of infection and from fear of media infiltration. (In Cape Town, a press photographer had actually found his way into the surgeons' changing room, donned a scrub suit, and boldly entered the operating room in an attempt to photograph one of the early heart transplant operations!). At the Heart Hospital, strict instructions had been given that no one was to be allowed into the observation dome of the operating room. With Donald Ross' support, however, I managed to persuade the authorities to allow me to watch from the dome, only to find that blinds had been pulled up to obscure most of the view of the surgical procedure! Although my view was necessarily severely restricted, I managed to see most of the operation between the blinds.

The surgery went well and the heart functioned very satisfactorily. At the end of the operation I joined the surgical team in the surgeons' lounge, where spirits were high. Dr MC Botha, the tissue immunologist from the Cape Town group, happened to be visiting London at the time and he joined us together with Dr James Mowbray from St Mary's Hospital, who had been invited to collaborate on the immunological aspects of the care of the patient. There was considerable discussion about the case and about transplantation in general. To a young surgical research fellow, it was an exciting experience.

While we were celebrating the success of the technical procedure, word came through that Dr Denton Cooley of Houston, Texas, had performed his first heart transplant on the same day. As Dr Cooley had a reputation for rapidly performing large series of cardiac operations, some wag at the Heart Hospital joked that Cooley would probably report his first 20 heart transplants within the next month. This did not prove to be so very far from the mark, as Cooley's

group performed no fewer than four heart transplants over the course of that weekend!

By the end of the evening, a relatively large group of the media reporters and photographers had formed outside the entrance to the hospital and it was felt that a representative of the surgical team should make a statement to them.

THE TIMES

Saturday REVIEW

MP's wife is trampled on by student in riot

Man of 45 gets new heart in first British transplant

Figure 1

It was decided that all of us present in the surgical lounge should participate and I can well remember standing on the steps of the hospital entrance with many other members of the hospital staff whilst a short statement was read about the procedure and the patient's progress.

The following morning photographs of the group appeared on the front page of nearly every national newspaper (Figures 1 and 2) and I gained considerable prestige, particularly amongst my lay friends, for being involved in this surgical triumph! I did not feel it necessary to shatter their illusions by mentioning that I had only watched the procedure from a crack between the blinds in the observation dome!

A full press conference was planned the next day. I was tempted to show up in the anticipation that further photographs would appear in the newspapers and would again impress my family and friends! However, as I had already missed a key training session on the river at Thames Rowing Club on the previous evening, I reluctantly decided to forego further fame in order not to lose my place in the rowing crew! I therefore went

Britain's first heart-switch man 'satisfactory'

The 18 who did it

Figure 2

down to the river and read about the press conference in the Sunday newspapers.

At about this time, there had been a campaign to improve the economy in Britain (as ever!) and everyone was being urged to show pride in British goods and achievements. It was fashionable to demonstrate that in whatever one was pursuing one was 'backing Britain'. In the euphoria of the moment, and in an innocent gesture to show that British surgery could compete with the rest of the world, some of the members of the surgical team at the press conference displayed cards on which were printed Union Jacks and the words 'I'm Backing Britain'. This subsequently backfired as it was incorrectly interpreted by some that the operation had been carried out for national pride rather than in an honest attempt to save the life of a patient. This was clearly not the case but the controversy initiated my painful education in how careful one must be in one's dealings with the press. (The satirical magazine 'Private Eye' mischievously embellished the photograph taken at the press conference and splashed it on it's cover (Figure 3)).

Figure 3

The cardiologist at the Heart Hospital who helped Donald Ross with the post-transplant care of this first patient was Jane Somerville, also a Guy's graduate. The patient initially did well but subsequently developed recurrent pulmonary emboli from a thrombus that formed in the residual native right atrial appendage that had been left in situ, and subsequently died after 45 days (8). He never left hospital. I played no role in his care but was able to keep in touch with his progress through my colleagues.

A second heart transplant was performed at the Heart Hospital, about which I can remember little except that it was not successful.

One apocryphal incident that reputedly occurred at the time of either the first or second heart transplant at the National Heart Hospital - I cannot now remember which - caused considerable amusement amongst the junior staff. The brain-dead donor was being transported rapidly by ambulance from the donor hospital to the Heart Hospital. In the ambulance, one of the surgical team

noted that his shirt tail had become caught in the zipper of his trousers and, even worse, the zipper had become jammed half open! It was known that a horde of press photographers and television cameras was waiting outside the Heart Hospital for the arrival of the ambulance. Most of the dash across London was therefore spent with one of the team making a frantic effort to free the zipper on his colleagues trousers! In the subsequent television broadcast, the dash across London was described in dramatic terms with details of the way the two 'surgeons fought courageously' to maintain the circulation of the donor and keep the heart pumping until they arrived back at the Heart Hospital. The truth would certainly have been less dramatic, put possibly far more entertaining!

The Use of an Animal Heart as an Auxiliary Pump

One other experimental step was taken by Donald Ross and his colleagues in early 1968 which is worthy of note even though it was unsuccessful. Ross' group was faced with the unusual circumstance of having two patients at the same time in adjacent operating rooms neither of whom could be weaned from a cardiopulmonary bypass support following open heart procedures. They reasoned that an animal heart inserted as an auxiliary pump might be able to maintain the circulation until either the patient's own heart recovered or a human donor heart became available to allow orthotopic transplantation. In one of the patients, a pig heart was therefore anastomosed in parallel as an auxiliary heart transplant (Figure 4) but, within four minutes of re-perfusion, was hyperacutely rejected (8)

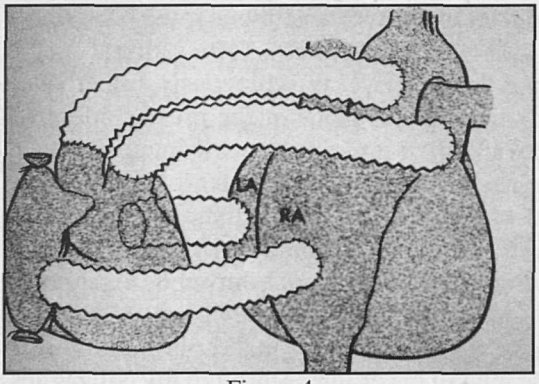

Figure 4

Following this experience, in the second patient a preliminary test was carried out by inserting the coronary perfusion lines from the pump-oxygenator into the coronary arteries of a pig heart to see whether the same response would occur. The reaction was identical, and so this heart was not transplanted.

Where the pigs were obtained, I cannot remember, but probably Donald Longmore had acquired them through his Royal Veterinary College connections.

The problem of hyperacute rejection of non-primate organs in humans has still not been resolved, more than 25 years later. Nevertheless, to Donald Ross and his colleagues must be credited the concept of using an animal heart as a 'bridging' device towards transplantation with a human heart, an idea that was taken up subsequently by Chris Barnard and has gained further support and interest in recent years.

Apart from the initial attempt by James Hardy to insert a chimpanzee heart in a human, there was only one other such attempt at cardiac xenotransplantation in the 1960s. Denton Cooley and his associates in Houston inserted a sheep heart into a patient on June 12, 1968, with an identical result; hyperacute rejection occurred immediately. The exact date of Donald Ross' procedures remains obscure, but almost certainly took place in the first six months of 1968, possibly before Dr Cooley's operation. Both Donald Ross and Denton Cooley have since told me that they feel mildly embarrassed about these attempts at cardiac xenotransplantation as they were highly premature. Although with the aid of hindsight this is clearly correct, the frustration of a surgeon faced by a dying patient sometimes leads him to take desperate measures. 'Diseases desperate grown, by desperate appliances are reliev'd, or not at all' as Shakespeare has written (Hamlet IV, iii, 9).

Figure 5

In July 1968, Donald Ross and James Mowbray participated in the first symposium on clinical heart transplantation held in Cape Town, to which one surgeon and one immunologist were invited from each centre in the world that had performed at least one heart transplant (Figure 5). By then, there were about 10-15 centres that had some experience. The proceedings of this symposium were subsequently published (9).

Donald Ross performed a third transplant, this time at Guy's Hospital, which proved his most successful to-date, the patient surviving several weeks, but again still not doing well enough to leave hospital.

The Years of Inactivity in the UK

Along with many other groups around the world, including that of Denton Cooley, Donald Ross' team came to the conclusion that the immunological problems were too great and no further transplants were performed at either the National Heart or Guy's Hospital.

Magdi Yacoub (now Sir Magdi) made one attempt at Harefield Hospital some time after Donald Ross' first three cases, but this patient did not survive the operation. Several years then elapsed before heart transplantation was resuscitated as a clinical procedure in the United Kingdom.

My own surgical training took me back to Addenbrooke's Hospital in Cambridge as a general surgical registrar, after which I completed my research (this time in the Thoracic Surgical Research Unit at Guy's) and training in cardiothoracic surgery (in Cambridge and London). I therefore effectively left the field of heart transplantation for some years (although during this period there was very little activity in it worldwide and none in the UK). My time spent with Professor Roy Calne (now Sir Roy, another Guy's graduate) in the Department of Surgery at Addenbrooke's, however, exposed me to kidney transplantation and to the exciting (if punishing) early days of liver transplantation and maintained my interest in this slowly developing surgical field. Sir Roy's outstanding contributions to the development of organ transplantation have been reviewed in the 'Gazette' (10).

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David K C Cooper

to be continued

Four Venflons and a Drug Chart

The Houseman's Review

Start spreading the news, there is some talent at Guy's! This year's production of the Houseman's Review was successful enough to re-establish the lost honour of house officers from being once thought of as consultants' poodles to the more generous *status* of artistic professionals (no sarcasm intended).

The awaiting audience were in eager anticipation of the show, which inevitably was organised at the last minute. However, laughter and wit were the order of the night and this cocktail of humour was supplemented with an excellent audition of music. The capacity crowd reciprocated well to the humorous collection of gags and innuendoes that were being delivered to them, enjoying the reddened looks of embarrassment upon the faces of the few representatives from the hospital hierarchy.

The opening sketch, which ultimately was the highlight of the show was a well co-ordinated military type display of a regime under the command of a fearful looking vascular surgeon, alias Sergeant-Major Taylor. The role of this surgical Buddha was well played, very funny and very life-like (*as I'm sure those of you who have attended his firm, will know*). Also, amongst the pick of the bunch was the 'Yorkshire men' sketch, in which the four would-be consultants described an ironic scenario- that the junior doctors of today don't work hard enough 'One in three that wer' lucky...in my day it wer' one in none'- though they can't really think that.. can they? Other topical issues were raised in a similar manner, though perhaps rather more indiscreetly (*I refer here of course, to the 'Love-child scandal'*). The comedy was matched gag-for-gag with acoustical magnificence from the hired band which com-

prised an excellent saxophonist. I suppose expecting the housemen to be able to make sweet music would be asking too much. However, the band's musical melodies did not go to waste, since the twanging guitars were frequently accompanied by the casts' secret vocal weapon, who, when she wasn't flaunting her stuff, was a doctor who appeared to like to play the nurse. Albeit, her voice was good and it would be fair to say that stretching those cords would be more profitable than her day job (*and I'm sure that's just what the doctor ordered*).

The end of the show was met with a fitting finale, sung by cast and audience alike... 'Start spreading the news, Guy's ain't closin' today...', though not quite in the same enigmatic style as 'Old Blue Eyes' but just as effective. In summary, the show was well worthy of the self-awarded GAFTA award, which was admirably accepted by the show's dogs-body (*not poodle!*)..credit to all the housemen (& SHO & Reg & Nurse) involved.

Rikin Trivedi

The Bluffers's Guide to the BSc

Untangling the Wilderness of those BSc journals

Having recently completed an arduous twelve months within the confinement of the medical school building, this torment, commonly referred to as a BSc, is finally over!!! I am only one of many aspiring young medics who elected to intercalate at the end of the second MB, with the hope of becoming tomorrow's Einstein. Ha! How many of us now feel competent enough to call ourselves scientists, I wonder? With the bickering about the long hours and lack of supervisory help aside, the BSc, which incidentally for me was Experimental Pathology, did teach me one thing.....to pass on anything that I may have learned to the next lot of naive would be scientists. So here is a quick guide, to which students are advised to refer, to understanding scientific literature.....the key to success in any BSc!! It is not only the reader that may benefit from this guide, I've found it an invaluable aid in writing scientific gibberish destined to blind the eyes of some unsuspecting individual.

When the author writes.....

'It is known that...'

He really means....

I can't be bothered to look up the original article but it's so obvious that I'm sure somebody must have done it.

'Of great theoretical/clinical/practical importance....' *I think that I am the only person in the field that finds it interesting!*

'Three of the samples in the results were selected for further study.'....*The rest of the experiments didn't work, so we salvaged this paper from these three insignificant results.*

'Sterile technique was used throughout....' *After contaminating our samples on 10 separate occasions, we finally got it right!*

'The figure shows a representative result....' *Actually, not all our experiments went this well...in fact only this one did.*

'....statistically significant....' *No actual statistical analysis was performed but we're quite sure that it is significant....to someone.*

'The results confirm the convincing findings of Smith et al., 1951' *He was one of my favourite students.*

'We believe that....' *Well, I think it's true.*

'It is generally thought....' *On this point, the rest of my laboratory also think I'm right...for once.*

'Clearly, additional work will need to be done to support the findings.' *I'm not quite sure what my findings are but I hope that you can't spot that from my discussion.*

'These findings warrant a further in-depth study....' *I have to say this otherwise my grant money for research into this miserable subject will be terminated.*

'I thank the following....for their constructive criticism and help....' *Actually the rest of the department told me that the work was a bag of ?#$*! but I carried on anyway.*

'Particular thanks are due to....' *I'm truly indebted to my BSc student for doing all the work and giving me my first publication in 5 years.*

Rikin Trivedi

Neurology

An Anthropologist On Mars - Oliver Sacks (ISBN 0330 337 173 Picador 1995)

This is the latest offering from the ubiquitous Oliver Sacks, the Bruce Forsyth of the neurology world. Oliver Sacks is the writer when it comes to recording interesting case histories for public rather than profession consumption. Professor Sacks' past work stands before him: 'Awakenings' and 'The Man Who Mistook His Wife For A Hat' put him on the map as a writer and neurologist. He is undoubtedly a lucky man, jumping around the world in search of the most interesting patients.The presentations in this book, as with the others, are accessible to the reader, aided by the clear writing style.

Sacks is apart from other writers because of his precise description, caring style and wide range of references. He calls upon all manner of topics from history, art and science to illustrate and explain the conditions he comes across. This book, a collection of articles already published in American magazines, contains seven paradoxical tales of the lives of people suffering with, to greater and lesser degrees, and dealing with neurological conditions. The first case concerns a painter with achromotopsia; then there is the tale of a 'hippie' caught in the past due to memory loss; a surgeon with Tourrette's (who still operates at the table!); the new difficulties facing a blind man as he regains his sight. The fifth tale describes another artist's who can only paint his home town in Italy as he remembers it as a boy. These are moving stories describing the sad side of life for these men. The last two tales record the abilities and difficulties of two savants suffering with autism.

The cases are compelling and the book is more interesting because of the copious footnotes giving the background details. An excellent read, highly recommended!

Richard Littlewood

Psychiatry

Basic Notes In Psychiatry (Revised Edition) Michael Levi Kluwer Academic Publishing £7.95 paperback.

This is a useful little book to accompany a psychiatry firm. Psychiatry, diagnosis in particular, it seems, depends heavily on the classification of illness and disease. There is of course the phone book like ICD10 and the DSM IV to keep even the keenest budding psychiatrist busy. This book is a bit like a ICD10 made easy, with a little extra. It has the important disease classifications and all the symptoms to look out for (this makes up the ICD's and the DSM's) in a simplified and accessible form. Unlike some of the other 'in summary - you will need to know this' type of books, this one is not too hectic and is clearly laid out with simple headings and sub-headings.

There are 11 chapters covering adult psychiatry, including history taking, symptoms, syndromes and conditions. Organic disorders, eating problems and personality disorders are also dealt with. The layout includes sections on definitions, epidemiology, classifications, clinical features, aetiology and management for most of the conditions mentioned. The sections on the aetiology are particularly good with references to the appropriate research and also details of analytical theory from the likes of Freud and Jung (psychiatrists run for cover!).

This type of thing always goes down well at ward rounds: a useful guide for psychiatry students.

Richard Littlewood

Practice what you preach!

In the opening chapter of Oliver Twist, lately renewed in our interest again as the musical 'Oliver', Charles Dickens wrote favourably of the workhouse in which Oliver was born, and in which he received his early upbringing: 'If...Oliver had been surrounded by careful grandmothers, anxious aunts, experienced nurses, and doctors of profound wisdom, he would most inevitably and indubitably have been killed in no time.' And the news that the oldest person alive - a lady of 120 living in France - gave up smoking three years ago, is hardly another boost for the health promotion lobby. Indeed nurses hold no good record generally for being non-smokers.

But maybe these are exception. For we are told that women overall suffer more greatly from the effects of smoking than men. And there are a few more interesting statistics: of people aged 25-34, 50% of the smokers are women while only 40% are men; the decline in smoking has been greater amongst men; more teenage girls than boys smoke; and families on low incomes still smoke at the same high rates as in the 1970s, although only 26% of women are overweight, as opposed to 38% of men.

I'm not sure what all this may mean, but as far as women are concerned smoking can affect fertility and increase the risk of cervical cancer. Also, in pregnancy, the foetus may be injured, and the menopause may occur earlier for women smokers, leading to earlier onset of osteoporosis.

Nurses in the past were rather better trained to care for patients who had an ailment, compared with the part they played in prevention. Nowadays the emphasis has changed: and we should all be aware that health promotion comes first. Our friends across St Thomas Street in Mary Sheriden House are indeed known as 'Health First', and their job is to promote better health across the inner London boroughs of Lambeth, Lewisham & Southwark.

Nurses undergoing training today with Project 2000, find their early education is devoted to identifying the areas where health may be improved through spreading knowledge to their clients. Health First works not only through the NHS, but also through the local authorities, voluntary agencies, and directly to the local population.

Health promotion is important for the future of the economy. Smoking, which has a great effect on the number of people suffering from coronary heart disease, is thus a major cause of both mortality and morbidity. If health can be maintained, and disease avoided, this will help the finance of our economy, and give hope for a better future. Nurses need to know more, and ensure

that they set a good example, as role models in promoting good health.

Men's health has been neglected in the past. This has been looked at by Optimum Trust, who provide community and family planning care for Lewisham & Southwark. They now operate 'Open for Men' on Friday evenings at the Central Clinic in Lewisham High Street. This provides an opportunity for men to seek confidential advice about their health if they are reluctant to approach their GP.

Health education has greatly prolonged the life expectancy for most of the population. Clean air and drains have done a lot more than medicine. Though, it must be said, the poorer section of the people - some of whom are close to us - still have a long way to go before catching up with the longevity of those who are materially better off. We are all living longer, and in the process creating economic and social problems, and spending many more years than our forbears in retirement. This has become a problem for nurses: many more are needed in the province of caring for the elderly. But as Samuel Johnson wrote in the Preface to his 1755 Dictionary: 'Life may be lengthened by care, though death cannot be ultimately defeated'. And we must recognise this. Death should not always be seen as a failure.

Denis Cobell.

Wolf George Tillman

Wolf Tillman died in Alderney on January 3rd 1995 after a short illness. He was born in Hamburg on August 9th 1912. His father, George Tillman, was a banker and his mother, Dorothea Wolf, came from New York where her father was a doctor. He entered Guy's as a medical student in October 1933 and started his clinical studies a year later. He married Charlotte Gebert on December 20th 1934 - it being most unusual in those days for a medical student to be married.

He qualified in July 1937, doing his house appointments at Guy's.He became Chief Clinical Assistant to the Medical Outpatients and also Skin Registrar and the day before war was declared he started work for the next four years as a physician at Guy's, together with Ted French. In 1943 he obtained the MRCP.

At that time, he was interested both in chest medicine and skin diseases but when he joined the RAMC in March 1944 he settled for dermatology. Wolf obtained his MD in 1947 and after leaving the RAMC started work as consultant dermatologist at the Miller Hospital; later he became dermatologist to the Woolwich Group of Hospitals, where he was also elected as Chairman of the Medical Committee, and continued in this role for many years. On Friday, 10th November 1972 he was given a farewell dinner at the Brook Hospital, which was hugely attended, and he retired from the NHS a week later. On the following day he arrived in Alderney where he made his home with Charlotte for the rest of his life.

I first got to know Wolf in the early 1960s when I became a colleague of his at St Nicholas Hospital, Plumstead. The Skin clinics were very large but somehow the patients were seen in an unhurried and kindly manner in spite of their numbers. He was a fine diagnostician and a greatly respected dermatological physician--a previous President of the Dowling Club and a member of the British Association of Dermatologists. As Chairman of the Group Medical Committee, which involved the Brook, the Memorial, Erith, and St Nicholas' hospitals, he made it his business to be on good terms with all of his many colleagues and his benign influence, seen best as he chaired Committee meetings, ensured that there was a happy, united and enthusiastic atmosphere amongst the staff at the various hospitals.

Over the last twenty years, I was able to enjoy his company, with Charlotte, on many occasions when visiting Alderney. Hospitality at 59 High Street and a crab or lobster meal at one of the many restaurants in the company of Guy's people were de rigeur. There would also be many reminiscences about Guy's people and their many inter-related connections, for Wolf's

main interest on retirement was people. Anyone coming within distance of the Alderney 'swinge' or 'race' was liable to be charmed ashore by Tillman hospitality and would no doubt be awarded the Guy's-Alderney tie. If you wrote to Wolf you would receive an instantaneous reply. Postcards would arrive from all over the world, for he travelled greatly in later years visiting friends and grandchildren; not only were they of interest from the places visited but provided a challenging competition as to who could decipher his writing.

His son Alan predeceased him but he is survived by his wife Charlotte, his son Peter, a General Practitioner in Jersey, and his four grandchildren. He was loved and respected by all who knew him.

GWS

CLJ writes:

The death of Wolf Tillman on 3 January 1995 at Alderney ends an era which began with Guy's open handed policy whereby refugees from Nazi Germany were made welcome. He came from Hamburg and entered Guy's in 1933. As a student he became a friend of RHS Thompson and together they translated a German monograph on the Erythrocyte Sedimentation Rate. Through him Robert Thompson met Wolf's sister-in-law, Inge, whom he later married.

Wolf qualified in 1937 and did the usual house appointments. He became a medical registrar in 1939 and I became a member of his firm in 1942.

He was a splendid undergraduate teacher, idiosyncratic, succinct, funny and accurate. But beyond these professional virtues he became a friend and a mentor for us all. He made no reference to what had happened in Germany, seemed deeply interested in us, and continued to be interested over the next 50 years.

He succeeded in joining the Royal Army Medical Corps in 1944, and served in the Far East (for political reasons) eventually becoming consultant dermatologist to SEAC and was demobilised with the rank of Lieutenant Colonel.

He returned to Guy's as a registrar in dermatology, and was soon (1947) appointed as consultant to the Miller Hospital in Greenwich. He continued his Guy's interests and contacts until his early retirement in 1972.

He went to live in Alderney but kept up his Guy's associations, at first by correspondence and later by contact with his friends when he visited the United Kingdom or they visited Alderney.

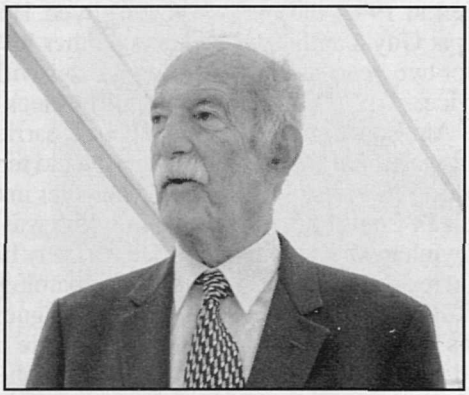
I met him after an interval of some years, in a hotel in Winchester when he was visiting his grandchildren who were at Winchester College. He was exactly the same, quirky, perceptive, humorous. We renewed a friendship which continued until his death, and

during that time I first realised how wide were his friendships and sincere his commitment.

In 1992 he was 80 and a great party was held in Sussex. We met many old friends, had a splendid lunch and then he made a speech without notes. He went round the room, starting with the most senior, identified each by name and place and date and offered an affectionate and witty comment on his career. And he was 80 then! When he had finished he sat down - then jumped up again and said, by the way, the wine that we had drunk had come from a vineyard which had been owned by his grandfather in what is now Yugoslavia!

His father had been an outstanding collector. His collections are now in the Victoria and Albert Museum, in the Fine Arts Museum in Amsterdam, and in the museum in New York. But Wolf collected people. He saw the best in them all, and in their wives and their children. He remembered them, encouraged them and offered them affection and consolation. He was an archetypal father figure and a great Guy's man.

CLJ



Dr Wolf Tillman

1912-1995

Dr Patrick Raymond Montgomery FRCP

Patrick Montgomery died suddenly in the early hours of Monday, 13 February 1995. He was born on 19 March 1922 and brought up in Bromley where his father, a Guy's man, was a greatly respected GP.

From an early age he showed an affinity for the Classics and these were his major subjects at school. On leaving, he was encouraged by his father to go into medicine and switching to the Sciences he managed to pass the first MB in eight months. He started as a medical student at Guy's in 1941, when the School was evacuated to Tunbridge Wells, and was one of the top brains of his year. He qualified in 1945, did his house appointments at Guy's and then served in the RAF for two years as part of his National Service.

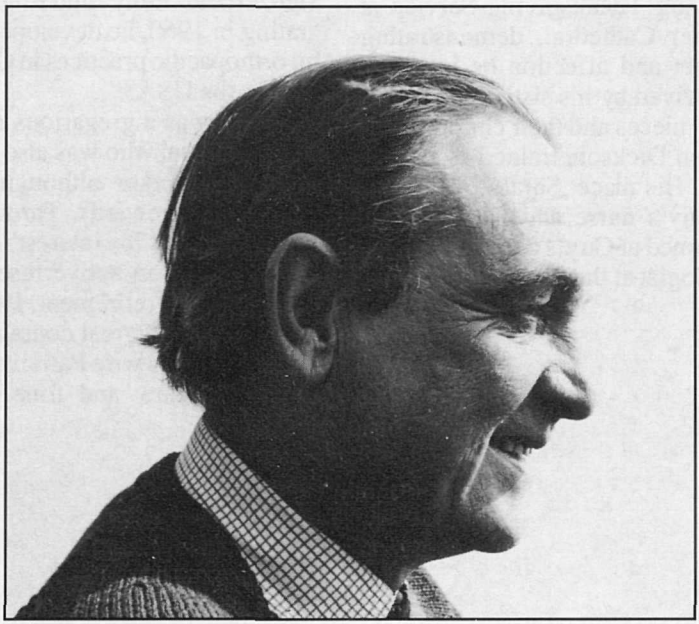
On leaving the Air Force, he returned to Guy's and was there for the next ten years, working mostly in the Skin department with Dr Louis Forman and Dr Edmund Moynihan and was in turn house physician, registrar and senior registrar. Dermatology was an ideal speciality for him as it suited his flair for observation and his classical and contemplative mind. He became a superb diagnostician and also a very successful treater of skin diseases.

During his time at Guy's he became famous throughout the hospital for the wonderful lyrics he wrote for the Residents' Plays, which were a highlight of the hospital's social calendar. The lyrics were brilliantly witty. A good number of the lyrics were published in the Gazettes for those years as part of the Reviews of the Residents' Plays. He also wrote serious poetry in spite of the difficulty in preventing his humour from breaking through.

In those days he lived in Trinity Church Square - at first at Mrs Young's and then at number 42 Trinity Street. For a while he was Warden of St Christopher's Hostel where he was responsible for the welfare of the students in residence but more often they looked after him. In 1958 he was appointed consultant dermatologist to the Wessex Region and worked in Basingstoke, Salisbury, Portsmouth and Winchester, where he lived. He was a familiar sight, wearing either his black bowler or his brown bowler with his monocle hanging round his neck and his notes packed into a plastic carrier bag. It did not take Wessex long to recognise that they had a real character in their midst as well as someone who was superbly good at his job. He was very highly regarded by his fellow dermatologists and by his other hospital colleagues and GPs and he was always available to help with difficult cases. He organised dermatological meetings for the Wessex Region and also for the British Association of Dermatology and his lectures to GPs were extremely popular - one, with typical humour, was entitled 'Spot Diagnosis'. He was loved by his patients, the nurs-

ing staff who worked with him, and who enjoyed his eccentricities, and by his devoted secretaries. He was someone who really enjoyed his work and was still actively working up until the time of his death.

He was an intellectual and an extremely erudite man for he loved words and the English language and always enjoyed philosophical discussions. He did not need much persuading at the dinner table to burst into poetry or, if there was a piano in sight, to sing one of his own songs or give a rendering, in his typically gravelly voice, of 'Does It Hurt You Very Much, Sir' or retell the tale of 'Dangerous Dan McGrew'. When he took up a hobby, and he had many, he became a real expert. He developed a great interest in botany, especially wild flowers, and had jam-jars and glasses full of specimens. More recently, his great joy was gardening which he practised in his cottage at Alderney and in St Clement's Street where the front garden was so full of plants and vegetation (often with their price tags on) that you practically needed a machete to hack your way to the front door. He loved opera, particu-



Dr Patrick Montgomery 1922-1995

larly Verdi and Rossini. He learned Italian during a period of enforced inactivity, due to illness, in 1957 so that he could appreciate the lyrics better and sing the songs himself. He spent his holidays with his close friends in many parts of Europe and in later years enjoyed barge holidays on the canals of France with the added pleasure of sightseeing and botanising. He had many holidays in Alderney and shared his cottage with his family and friends. He was marvellous company and enormous fun to be with. He was a rare wit and knowledgeable about so many things. A large number of people came to a moving Thanksgiving Service at Winchester Cathedral, demonstrating the respect and affection he inspired. He is survived by his sister and by his nephews, nieces and their children. His sister, Pam Dickson, trained as a nurse at Guy's. His niece, Sarah Collis, was also a Guy's nurse and her husband, Chris, trained at Guy's and is a consultant oncologist at the Royal Free Hospital.

GWS

Gerald A Marin MB FRCS ENG, ED & Can

Died at St Joseph's Hospital, Hamilton, Canada on the 16th of February 1995 at the age of 72, from the complications of diabetes.

Gerald came to Guy's in 1946 after wartime service with 307 squadron RAF fighter command with whom he completed two tours of operations on Mosquitoes. He qualified in 1952 and went on to specialise in Orthopaedic surgery at Guy's.

Born in France, he was educated in Switzerland, Kenya and England. Emigrating in 1960, he developed successful orthopaedic practices in Canada and later in the USA.

Gerald was a gregarious and generous individual who was also a compulsive hard worker although he cared little for the rewards. Throughout his life he retained his interest in the military and was an active reservist until age forced his retirement. He faced his last illness with great courage.

He leaves his wife Patricia, two sons, daughter-in-law and four grandchildren.

WAM

Dr Paul Davies

Paul Mervin Davies TD, MBBS, DPH, DMR, FRCR, FFR, died suddenly, on the tennis courts, on 26 February 1995, aged 81, near his home in Guildford, Surrey.

Paul qualified from Guy's in 1937 and just had time to acquire his DPH before the outbreak of war, when he joined the RAF Medical Branch with which he served mainly in the Middle East (twice mentioned in despatches). After the war he turned to radiology and was later an assistant radiologist at the Brompton Hospital before becoming Consultant Radiologist in SW Surrey Health District. He was a former commanding officer of 10th London General Hospital RAMC(TAUR),

Much loved husband of Helen and loving father of Gwenda.

Clubs Union report

The student union body functions as an elected team to run the sporting and social facilities at UMDS. We hope to make an article in the Gazette a regular feature to inform students exactly what is going on behind the scenes as well as the more obvious work that we do. The fourteen members of the present student union have now been in office for six months under the control of our first sabbatical president Oliver Harley. It was decided last year that the demands of the job could not compete with clinical work so, as in the majority of London medical schools, a sabbatical president was set up. Ollie has been busy reorganising the student union as well as negotiating for a medical guild to be set up, so we can remain financially and socially autonomous within King's College and not be swallowed up after the impending merger. We hope to bring you a full report of this in future issues of the Gazette.

The two vice presidents, myself on the Guy's campus and Justin Rodgers on the St Thomas' campus, are involved in the everyday running of campus life backed up by two social secretaries and Jon Aung our weary treasurer. For this article I would like to raise the issue of the future plans for the development of the Spit dining room and the reorganisation of space in Boland House.

For the last few years, due to fire regulations, the ballroom on the first floor in Boland House has been out of action. For us to be able to use it a new fire escape must be installed. Originally an escape to the footbridge leading to Philip Harris House was planned, but this has fallen through so now an internal escape has to be built.

These more extensive modifications to the first floor have led the United Clubs and the medical school to believe that a complete reworking of the first floor and the Spit is necessary. Ideas for the use of the floor space have included a postgraduate bar, a sports clubs office, a larger committee/conference room and a coffee-type lounge in the Spit which would be an alternative social area to the bar and would cater for those students who prefer an evening away from the bar atmosphere. We also hope to introduce Sky television to the proposed lounge in the Spit. As yet none of these plans have been finalised, we only know that there should be funding for extensive change. It is up to the student body to decide exactly what is needed hence I am trying to gauge the views of students on the matter.

If you feel that there is something that is needed, or if you have ideas for different social areas, or your own plans then let me know in writing via the student union pigeon hole.

With the future amalgamations that are planned, and the ever tightening fire regulations, we have to think about catering for additional social requirements, but we will certainly take into account any suggestions. The alterations to the building may start as soon as this summer, so if there are any ideas it is important to get them in soon. We will keep you updated on any future developments in further issues of the Gazette.

Ben Eddy
Guy's Vice President

Rugby

Courage League Guy's v Old Guildfordians
HOP 25th February 1995

The rain relented at last for the penultimate league match of the season against the team in the number 6 spot. The Guy's side has proved itself best on dry, firm ground. Heavy wet ground has proved its undoing against bigger sides as shown both in the League, the Surrey Cup and of course in the narrow defeat to St Mary's in the Hospitals cup. The ground at HOP remained heavy but the spectators were hopeful that Guy's would be able to secure their position in the league with a victory.

Guy's got off to the best possible start when they kicked off and Challacombe, rose and secured the ball which was then passed rapidly across the field, won in two consecutive rucks and Ugo raced around the winger and under the posts to make the score 7-0. This really was an excellent try and it was the speed of the handling which was most impressive and also perhaps the fact that not a single opposition player had touched the ball whereas it had passed through most of the Guy's side. Guy's then embarked on a good period of play and when Old Guildfordians collapsed the scrum on their line a penalty try was awarded and converted by Davies.

The Guildfordian side however were showing that when given the ball they were an excellent handling side and made a number of dangerous forays into the Guy's half. On one of these the Guy's centres were caught off-side in front of the posts and the resulting penalty converted for a 14-3 score. As the pitch became wet, Guy's embarked on some of their famous rolling mauls and at one stage made some 20 yards down the field, and at this stage of the game were playing with great cohesiveness. A further try was scored and converted by Davies before half time when after a series of good moves and excellent handling by the Guy's backs Davies was caught short of the line but somehow escaped the tackle to get over.

Thus at half time the score was a respectable 21-3 to Guy's who were beginning to play with real zeal and enjoyment. Despite the loss of Ryan and Davis from the back row due to injuries the pack had played very solidly and the backs had shown real skill in moving the ball at speed. The new players in the side, Ansell at second row, and Sharp in the back row emulating his father, Hugo in the 1960's, had very good games. One worrying feature of the play was the amount of penalties conceded, neither the coach nor the captain should be satisfied with that whatever the result. A penalty by Davies preceded another fine try when, after a quick break, Davies chipped ahead and allowed Bevan to gather and crash over. Davies then ghosted through for another try for some 25 yards up for another spectacular individual try. Davies had an outstanding match but among a team that played well Bevan on the right wing, Burt at full back and Llewellyn and Challacombe in the back row had notable performances along with Barrio who won a considerable amount of ball in the line out. The final score of 38-6 was an accurate reflection of Guy's superiority on the day.

Team: Lutz, Dai Evans, G Tsolakides, E Barrio, Ansell, Sharp, Llewellyn, B Challacombe, John Davies, Neil Davis, F Ugo, Jenkins, R Breeze, Bevan, J Burt.

SJC

Qualifiers December 1994

The following student passed the first of the new examinations of the United Examining Board and qualified LMSAA(Lond), LRCP(Lond), LRCS(Eng) in December 1994:

Bhattacharya, Miss K F

The following qualified MB BS(London) in December 1994:

Ahilan, R
Bhattacharya, Miss K F
Chana, Miss T
Dave, Miss S
Liu, H L
Maccallum, N S
Maslen, T P J
Masood, J
Mehrotra, R
Mohanan, Miss D
Moncrieff, M D S
Nayyar, N S
Qureshi, M A
Radford, S R
Rahaman, Miss N
Shankar, Miss S
Shergill, S S
Singh, R
Torok, R Z
Warden, M G
Zaki, Miss N D

The following qualified MB BChir (Cambridge) in December 1994:

Kozielski, Miss Y

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Mugswell
Coulsdon
Surrey CR5 3SY
Tel: 01737 557564

Rugby Football Club

The Rugby Football Club, will be holding its annual, end of season ball, at the Trafalgar Tavern, Park Row, Greenwich (adjacent to the Royal Naval College), on Friday 19 May 1995. Tickets will be on sale in the Spit Dining Room during the lunchtime periods of Tuesday 9 May and Wednesday 10 May 1995.

Memorial Service

A memorial service was held for Miss Antonia Butler, a final year medical student, on 4 April 1995 at St Michael's and All Angels Church, Ascot.

Death

Panis-Piper, R F, died 30 January 1995.

Miss Joyce, Ethel Florence, died 3 February 1995 after a long illness. She nursed at Guy's during the Blitz and afterwards became involved in psychiatric nursing.

Neve, Richard Clement. Qualified MBBS 1945 Guy's. FRCS, FRCS(C). Died on 12 March 1995 at his home at Wycliffe, British Columbia.

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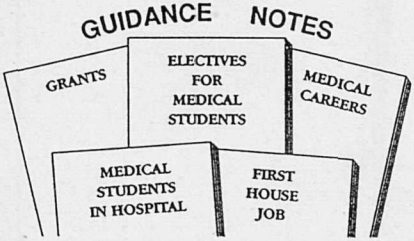

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- Anaesthesia in Wonderland
- Dental Society Clinical Day

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UMDS Guy's
12 JUN 1995
Wills Library

Guy's Gazette

Editor Alamgir Kabir **Assistant Editor** Ujuala Capoor **Sub Editor** Sue Ferguson **Features Editor** Sanjay Varma, Roopa Mehta **News Editor** Mazhar Afaq **Review Editor** Richard Littlewood **Sports Editor** Rikin Trivedi **Layout** Chandra Pasapula **Nursing Notes** Denis Cobell **Office Manager** Margaret Flanders.

The opinions expressed are those of the authors and do not necessarily represent the views of the Hospital.

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Passim

The House of Commons debate on healthcare in London was won by the Government. There were a number of abstentions by conservative MPs and some even voted against the Government. However many are still unhappy with the present state of affairs. The future is uncertain but the fight is certainly not over.

Work on the Tower Reception area is in full swing. Unfortunately one has to traverse a number of walkways that are wholly inadequate as exits and avoid workmen who toil precariously close above. Let us hope that the final result will be worth it when the redesigned reception area is complete.

The area next to Shepherd's House has in recent weeks borne witness to a number of innovative schemes by members of the catering team not least to mention an ambitious attempt at a barbecue. As to how well this stall was frequented is debatable but at least it shows effort on the part of the staff.

Rag Week has yet again descended upon Guy's. Many students went out collecting and there was the inevitable Hit Squad with its usual dose of poor taste and revolting concoctions. Nevertheless a Rag Week would not be a Rag Week without them. A vote of thanks is in order to the organisers.

For the final year students the exams are drawing near. They are the last year at UMDS to sit all their finals in one go which as any old student of Guy's will testify is no easy task. Years below this final year are sitting their exams over the length of their clinical training attachment in an attempt to make their final year more of an apprenticeship and increase the amount of 'hands on' experience. This cannot be a bad idea. Medical education is changing and it seems that UMDS is attempting to keep up with these changes and continue to produce sound and competent doctors of the future.

Campaign Update

Dear Sir,

As I write, there is a quiet lull between two pretty noisy storms. Mrs Bottomley has made her announcement about the future of Guy's - but the House of Commons has not yet debated and decided whether it agrees. The huge efforts of the Guy's community, local residents and our friends worldwide have won certain victories - of which delaying the immediate closure of Guy's Accident and Emergency Department is the most significant. But many things are still undecided.

The long term future of the A&E Department, the future number of Guy's in-patient beds, the ultimate use of Philip Harris House, the use of the parts of New Guy's House and the Guy's Tower which King's College London will not now need, whether we keep an ITU, and the money available for the Trust and the local health authority are the most important.

All this means that the campaigning for Guy's will go on. Whatever the exact make up of uses on the Guy's site, we have been promised that the hospital will continue.

If you have not done so already, please join the Save Guy's Campaign - by contacting us at: PO Box 4016, London SE1 9TG, or telephoning us on: 0171 357 9260 now to show your support. The NHS in general and Guy's specifically are amongst our greatest national assets. How safe they are depends as much on us as on the Government. It is a privilege for all of us to have such a worthy cause and such a brilliant hospital to campaign for.

Yours faithfully

Simon Hughes
MP for Guy's Hospital
Chairman - Save Guy's Campaign

Surgeons' Boycott

Dear Sir,

In your March edition you repeated the news story printed in the Evening Standard and Daily Telegraph regarding a boycott by surgeons at Guy's Hospital in response to the proposed closure of the Intensive Care Unit. In the press it was reported that the Orthopaedic surgeons did not support such a boycott.

What in fact was said by the Orthopaedic surgeons was that they were in favour of the Trust's aspiration to establish an elective Orthopaedic centre within the Philip Harris House, that the requirements of an elective Orthopaedic centre for intensive care facilities is low, and that we feel provided there was a provision for high dependency beds within the unit, we would be satisfied with this.

Patients in whom the need for cardio-respiratory support could be an-

ticipated would obviously not be suitable for such a unit, and would have to be operated on at St Thomas'.

Yours faithfully

Mr D Nunn FRCSEd (Orth)
Consultant Orthopaedic Surgeon

The B12 Factor

Dear Sir,

Denis Cobell (Nursing Notes, Guy's Gazette, March 1995) writes that he favours a vegetarian diet, and it is true that there is much to recommend vegetarianism from a nutritional point of view. Vegetarian diets typically contain little saturated fat, and ample anti-oxidant nutrients and also dietary fibre. However, I was disturbed to read of doubt expressed about the orthodox view that: 'a vegan diet, with no food of animal origin, is deficient in Vitamin B12'.

It is true that Vitamin B12 deficiency disorders usually occur as a result of acquired gastrointestinal disease, and these disorders may not occur in vegetarians in the less developed world, because of microbial contamination of their diet, so that sufficient bacterially synthesised vitamin B12 is obtained.

However, there is much evidence that Vitamin B12 deficiency constitutes a real hazard in unsupplemented vegan or vegetarian diets (Sanders & Reddy). In a study of 132 vegetarians (Tungtrongchitr et al) it was found that serum Vitamin B12 levels decreased according to the duration of vegetarianism, and 'in the females practising vegetarianism for 6-10 years or more, the proportion of deficiency was particularly high'. Haematological and electrophysiological effects of Vitamin B12 deficiency, secondary to vegetarianism, have been recorded (Gilois et al) and these may be 'associated with long term neurologic consequences in infants' (Graham et al). Maternal vegan diets can cause serious neurological disorders in breast-fed infants, due to vitamin B12 deficiency (Kuhne et al) and, at the other end of the age scale, increased risk of Vitamin B12 deficiency has also been reported amongst elderly vegetarians (Lowik et al)

Yours faithfully

Francis Reed
Division of Biochemistry and Molecular Biology

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Tungtrongchitr R et al, Int J Vit & Nut Res, 63(3), 201-7, 1993

St Christopher's House

Dear Sir,

Rikin Trivedi and the Chrissies Boys he wrote about in the December/January issue may like to know that St Christopher's distant past was almost as colourful as the recent days that he describes.

Writing from memory, the building started out as a sewing machine factory in the mid-19th century, before becoming a warehouse. In the 30s it was converted into a boy's Borstal. The last War saw its most romantic years, when it became a hostel for men of the Free Norwegian Navy, under training, and must have welcomed numerous Norwegians who had braved the hazards of escape across the North Sea as described in the Shetland bus. I imagine that was how it got its name.

The School bought St Christopher's shortly after the war with a grant for the University approved after the great Douglas Logan had visited it on Derby Day. He must have decided it was at least a stayer even if it would never be a winner.

Yours faithfully

Donald Bompas

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Future of Guy's: Secretary of State's Announcement

In her announcement of Tuesday 4 April on the future strategy for Guy's and St Thomas' Hospital Trust, Virginia Bottomley said:

'I have decided to accept the proposals for the concentration of acute services provided by the Guy's and St Thomas' NHS Trust by developing St Thomas' as the main site for acute in-patient and emergency services, and developing Guy's as a hospital for local people providing a range of services including a minor injuries unit, out-patient clinics, day surgery facilities and in-patient beds for planned, non-emergency treatment for people on waiting lists. Guy's would also retain the dental hospital and school, and would provide mental health services including in-patient beds. I have made clear that the Guy's A&E Department and supporting beds are not to close until alternative facilities are in place and working satisfactorily, which I understand will not be before the end of 1998. I have also decided to accept the proposal to transfer kidney transplant operations from King's College Hospital (Dulwich) to the Guy's and St Thomas' NHS Trust.'

'The changes which I have agreed will strengthen specialists services by concentrating them in fewer, better centres of excellence and provide modern acute hospitals closer to major centres of population. Together with major planned investment in primary and community health services, they will take forward our aim of improving healthcare for Londoners.'

Pay Award 1995-96: The Trust Offer

Guy's and St Thomas' Hospital Trust has made an offer to its nurses, midwives and professions allied to medicine of a salary increase of 3.25% payable from April 1 1995.

This is made up of a 1% increase in national salary levels plus a local award from the Trust of 2.25%.

The Trust has been meeting with Staff Side during April to discuss the offer formally and seek an early settlement.

Student leader warns that medicine will be for 'rich kids' only

Medical students face particular financial problems which are not encountered by students in other disciplines. They have longer courses and very little vacation time in which to earn money; they have to purchase medical equipment, many more expensive textbooks than most other students and greater travel expenditure. However medical students are assessed in the same way as other students for a maintenance grant and are only entitled to borrow the same amount from the Students Loans Company as other students.

In November last year, Dr Sandy Macara, BMA Chairman of Council, wrote to the Secretary of State for Education highlighting these special circumstances and the effects of the Government's student support policies on medical students. Tim Boswell MP, Under-Secretary of State for Further and Higher Education, finally replied in February and said that neither he nor the Secretary of State were prepared to meet the BMA to discuss the issue - indeed the Minister failed to acknowledge many of the medical students' concerns.

The Chairman of the Medical Students Committee of the BMA, Rupert Gauntlet, said: 'We are bitterly disappointed with the Government's response. There is a real danger that we will return to the days when medicine was the exclusive preserve of people from a financially secure background. That situation would be bad for doctors and bad for patients. Doctors need to be recruited for the widest possible base, not merely from the most well-off groups in society.'

The BMA has written to MPs and Peers of all parties to express the Association's fears for the future.

Public Affairs Division of the BMA

Professor Rodney Grahame

Professor Rodney Grahame, Professor of Clinical Rheumatology and Consultant Rheumatologist at Guy's, has been reappointed as Chairman of the Disability Living Allowance Advisory Board.

He has been in the post since 1993 and his reappointment for a further five years took effect from 5 April 1995.

The Disability Living Allowance Advisory Board advises the Secretary of State for Social Security on the Disability Handbook, which explains how medical conditions are likely to affect mobility and care needs.

Medical student stress at UMDS

Dr J H Thomas, the Pre-clinical Dean, organised a morning workshop to discuss medical student stress at UMDS on 1 October 1994. The workshop was instituted after the first SMEC stress survey was circulated and was attended by a large contingent of SMEC Year Representatives. Around forty people were at the workshop, including pre-clinical and clinical advisors, councillors, psychologists and several tutors.

The workshop was chaired by Dr Thomas and following presentations from SMEC on the Clinical Survey, there were several other presentations relating to stressors and the results of stress in various medical student groups. The presentations included topics such as debt, alcohol consumption, 'Stress in Medical Students' and 'The Role of Advisors and Tutors at UMDS'.

Following the presentations there was a plenary discussion session with nearly all aspects of medical student stress at UMDS being discussed in a lively session. Some of the ideas proposed included the setting up of a 'one stop student advice centre' where students could go for advice on a wide range of pastoral and other services. This would bring together and co-ordinate several of the support services which most agreed would be the optimum way to deliver pastoral support. The 'student well-being committee' and other SMEC proposals were also discussed. With so much to discuss it was decided to gather the interested parties together again in order that concrete proposals may be formulated.

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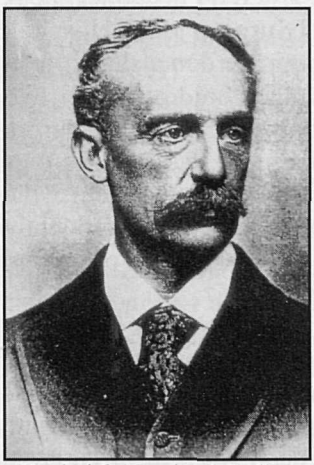
Frederick Newland-Pedley

The birth of Modern Dentistry at Guy's

Newland-Pedley was born in London on 21 July 1855. He was the younger son of Frederick Pedley a Dental Surgeon and was baptised in the names of Frederick Newland. He changed his name by Deed Poll dated 31 December 1888 to Frederick Newland-Pedley.



Frederick Newland-Pedley

Newland-Pedley's grandfather was Joseph Pedley who was a Shell Fishmonger with premises at 373 Oxford Street, he bought the properties in Camden Road for his daughters (Newland-Pedley's aunts) in 1839. He also bought number 16 South Molton Street for £920 in 1827 and 48 South Molton Street in 1835. The properties eventually passed to Newland-Pedley and formed a significant part of his estate.

Newland-Pedley and his brother went to Dulwich College by which time their parents had moved to Sydney, Australia. His brother also became a Dental Surgeon, qualifying in 1870 and retiring in 1906. He became a collector for Sydney Museum. He was the amateur athletic champion for his State in the mile and the 440 yards swimming champion. He was unmarried and died on 30 May 1918.

Newland-Pedley returned from Australia to study Dentistry. As he had assisted his father in practice, he was persuaded by Henry Moon (a friend of his father), Consultant Dental Surgeon to Guy's to enter the Dental Hospital in Leicester Square where he qualified LDSRCS in 1880. Unfortunately his student records from the Royal Dental have been destroyed but his record at Guy's, where he studied for the MRCS which he passed in 1881 and the FRCS in 1895, showed that he was an outstanding student. During these years he

coached many students and acted as assistant to Henry Moon. It soon became clear that he was an excellent teacher and he boasted that only two of his students had been referred in examinations. It has been written that he was unhappy at Leicester Square as it did not suit his temperament. In 1885 he had started to reform the Dental Department at Guy's and he introduced Conservative Dentistry instead of the wholesale extraction of teeth.

In 1885 he was appointed Assistant Dental Surgeon to Guy's and then in 1887 the post of Dental Surgeon to the Hospital was advertised and Newland-Pedley's application was successful. At that time dental treatment consisted of extractions but Newland-Pedley was concerned about this and soon persuaded the Hospital to provide a special room with two dental chairs which he ran at his own expense, including the cost of the nitrous oxide. He was then able to undertake conservative dentistry and was assisted by his colleague R Wynne Rouw who at that time was Assistant Dental Surgeon to the Hospital. He wrote to the Lancet in 1889 about the arrangements in the dental department at Guy's. 'There are two dental surgeon's dressers: they hold office for two months. A fresh dresser is appointed each month, who becomes 'senior' during his second month of office. The dressers attend daily at 12.30 to see outpatients. In very urgent cases they are at liberty to give 'gas', but of course the administrator must be a 'qualified man'. General practitioners are frequently asked to give 'gas' for dentists, and it is to be regretted that they so often find themselves lacking in practical knowledge on this subject.'

Newland-Pedley attended Guy's on Thursday and Friday at 1.30. On Thursday he did gas extractions and surgical cases. Apparently gas was used for the severer operations and in the numerous cases where the health of the patients rendered them physically incapable of enduring pain without severe suffering. On Friday he worked with Wynne Rouw and they dealt with fractured jaws, orthodontic treatment, and prosthetic work particularly for those who had experienced major jaw surgery. The rest of the time on Friday afternoon was devoted to 'stoppings' including gold! At one time Newland-Pedley was paid £40 per annum to cover the cost of dentures and other appliances but took it upon himself to pay all the other running costs which were £50 for 'gas' and £30 for instruments and stoppings etc. Thus the costs for running the Department were about £150 per annum. In a letter to the Lancet in 1889 Newland-Pedley advocated very forcefully that teachers in dental schools should be dually qualified but recognised 'the difficulties thrown in the way of a dental

student desiring a medical qualification are so great ...' This comment could have been written in 1994!

Newland-Pedley was also Dental Surgeon to the Evelina Hospital for Children and the North West London Hospital. He became a member of the Odontological Society of the Royal Society of Medicine in 1882 and a member of the British Dental Association.

The demands on the new dental clinic at Guy's increased rapidly as students, nurses and others working in the hospital requested treatment which made Newland-Pedley realise that there was a need for much more help. He wrote in the Guy's Hospital Reports in 1887 that the enormous amount of dental disease amongst the poor could only be dealt with by the establishment of dental schools with the treatment being provided by students and therefore another Dental School in London was indicated. This view was opposed by the Dental Hospital in Leicester Square and the 'National' (later to become part of UCH) as they claimed that they could meet the dental demands. Newland-Pedley then started to refer large numbers of patients to both Hospitals and he said 'we even filled their staircases'. The authorities at Leicester Square had to admit that they could not treat all these extra patients and indeed asked him to stop referring patients, so he had proved the need for a Dental School. He prepared plans for a Dental School at Guy's which were presented to the Staff in 1888. He was able to refute the arguments about there being no need for another dental School by citing the fact that the patients could not be treated elsewhere. The Governors finally agreed to the plans although the view was expressed that a Dental School would be very expensive.

Newland-Pedley was most fortunate in having the support of the Dean of the Medical School, Dr (later Sir) Edwin Cooper Perry already known for his work in creating the residential College in Great Maze Pond. Newland-Pedley said, 'his unlimited powers of organisation carried him from one great work to another until it is truly said that he had left his name written on every wall of Guy's'. A room was erected and equipped with

Early Conservation Room

twelve operating chairs and this formed the first Conservation Room which opened in 1889. There was even one electric engine installed. The School expanded rapidly and in 1891 Stephen ward in Hunt's House was made available on a temporary basis following the opening of the College. The first permanent building for the School was built and opened on 17 July 1893 by Sir John Lubbock. In addition to housing the Dental School it also contained laboratories for Chemistry, Physics and Bacteriology. Dr Cooper Perry, worked closely with Newland-Pedley, who was appointed Director of the Dental School with WA Maggs acting as assistant. The close association between the Medical and Dental Schools has continued ever since that time.

After his period as Dean of the Medical School Dr Cooper Perry was Superintendent of the Hospital for 23 years and also Vice Chancellor of the University of London. He was also made a GCVO and died in 1938.

Newland-Pedley was particularly interested in jaw injuries and presented papers to the Odontological Society of the RSM, and these have been recorded in the Transactions of the Society. A further contribution was made to the British Dental Journal in 1889 in which he described four cases of fractured inferior maxilla (the mandible), two of which were treated with Gunning Splints and another with a barrel bandage. The fourth was treated with a Hammond Splint.

He published another paper which concerned the case of a patient who had a gold filling inserted into necrosed bone by a fashionable dentist, presumably this was made of cohesive gold! He also wrote in the Guy's Hospital Reports about the use of Cocaine in Dental Practice and stated: 'To my mind the factor of plain danger constitutes an insuperable objection to the adoption of cocaine as a substitute for nitrous oxide in tooth extraction, but I consider that it may be used with advantage in opening up a diseased pulp prior to the application of arsenious acid, and in dulling the pain that is occasioned by the silk ligatures used in adjusting the rubber dam to teeth that are to be filled'.

Another of his main interests was the provision of Dental Surgery in General Hospitals and how to reform the Dental Departments in our Hospitals. In 1887 he wrote a thought provoking paper in the Guy's Hospital Reports about the role of the Dental Surgeon in a General Hospital. He recommended that all medical students should have some knowledge of dental problems. 'From lack of opportunity to acquire knowledge, a condition of utter ignorance on matters dental exists amongst the majority of medical gentlemen, and constitutes an

injustice and disparagement to dentistry, preventing the more cordial relationship and sympathy that should exist between the two kin professions, and often resulting in mutual recriminations'. He advocated that there should be a dental department in all major hospitals. In this same article he wrote that medical practitioners had little knowledge about the administration of 'gas', a situation which was common even after the last war when the local GP would be invited to give an anaesthetic for an extraction. He stated that 'the field for original research is limited' (in dentistry). He would have been very surprised to learn that there were no less than 500 papers presented at the British Division of the IADR in 1993 and this is only one of the many divisions in the world.

Another of Newland-Pedley's great interests was the education of students and in 1889 he described the situation at Guy's where the new Dental School had been opened. He commented as follows: 'Anyone familiar with metropolitan hospital practice must be aware that no attempt has hitherto been made to give thorough treatment to Dental Outpatients, for the simple reason that such cases can only be effectually dealt with in a school where the labour of skilled dental students can be utilised under the daily tuition and supervision of a considerable special staff'. He made the very important point that Dental Schools should be associated with general hospitals. He wrote: 'Instead of leading a wandering existence between a Special and a General Hospital, the Dental Student at Guy's will be able to obtain his whole education beneath one roof and among Medical Students. He will receive all the benefits that occur from study in a great Hospital instead of two small ones, and will undergo his professional training in the midst of Medical Students'. He extolled the importance of training in manual skills which at that time was achieved by prospective dental students serving an apprenticeship for two or three years in a dental laboratory or 'workroom' before starting the dental course. The numbers of dental Students increased rapidly and until the inception of the Health Service in 1948 they were all male at Guy's.

At the start of the Boer War in 1899 there was no provision for the dental care of the troops either at home or abroad. Dental disease caused great problems as large numbers of men were invalided home because of severe dental caries. The scale of the problem was such that one third of total admissions to hospital for dental caries were subsequently invalided home. Five thousand soldiers were found to be unfit for duty because of lack of dentures.

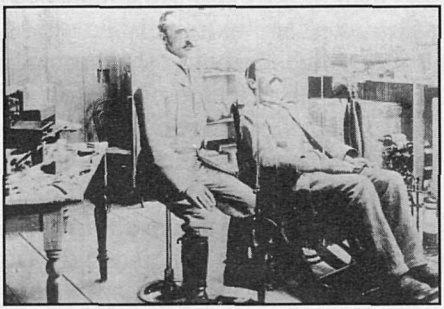
When the Imperial Yeomanry went to South Africa Mr (later Sir) Alfred Fripp, Assistant Surgeon to Guy's, was appointed as the Chief Surgeon to the Yeomanry and was asked by the War Office to assemble a team to care for the casualties; he asked Newland-Pedley to join the team at his own expense. Newland-Pedley, the first ever Dental Surgeon to be asked to care for the British Army accepted the challenge. He was to be responsible for 150,000 men and had little idea of the work that would be required. He was told that there were a considerable number of head injuries and also there were thousands of soldiers suffering from toothache and other dental problems. He therefore started to assemble every item of equipment and materials that he could think of so that he could manage any problem that arose. He had three dental chairs and much equipment, most of which was supplied by Ash's, but he also took a lot of items from his own practice. He purchased 5,000 gallons of nitrous oxide and this was put in metal cylinders provided by Ash's. The shipping company 'were more worried about the gas than the ammunition'. The equipment and stores all had to travel as personal luggage! Newland-Pedley wanted to take some students with him to help with the work and got approval from the Royal College of Surgeons that they would be exempt from six months of the LDS Course for this 'Elective'. Unfortunately the War Office would not allow the students to go to the War and so he had to go without assistance.

The equipment made up into twenty parcels weighed two and a half tons and so a pantechnicon was hired to take everything to Waterloo Station and with the help of students it was put on the train to Southampton where it was loaded onto the White Star Luxury Liner the SS Majestic.

She was used for two troop runs in the Boer War. The first was from Liverpool on December 13 1889 and the second left Southampton on February 12 1900. Newland-Pedley travelled as a Consulting Dental Surgeon on this latter voyage with the staff of the Imperial Yeomanry Hospital and described his experiences in an article in the Lancet published in 1901.

Two days after arrival in Capetown he was sent 500 miles north to Deelfontein where the Imperial Yeomanry tented base hospital was located. Deelfontein, 30 miles south of De Aar, was chosen as the site for a tented hospital because the railway line ran through the area. It had a hotel, the name of which was changed to the Yeomanry Hotel, but this closed down recently and is now in a neglected state. Deelfontein had a plentiful supply of water and at 4,600

feet above sea level was a healthy place for convalescents. It offered a great contrast to the arid vastness of the Karoo desert. The authorities rented an area from a local farmer and the hospital was established. The Railway built a special siding for ease of unloading the wounded and sick from the battle area. Newland-Pedley recorded that his equipment was moved from Capetown with great difficulty over very poor roads by ox cart and steam traction engines.


Newland-Pedley's surgery in Deelfontein

Fripp was accompanied by his wife and later one of her activities was to edit the garrison parish magazine, copies of which are held in the Royal Army Museum at Millbank. Fripp contributed several letters to the British Medical Journal in 1900 describing the work of the Hospital. The Hospital was on an excellent site with 520 beds, later increased to 750, with a personnel of about 200. He complained about the number of women who had come out from England. They were mostly ignorant and untrained, they were greatly in the way and were very indignant when told they were not wanted!

Criticisms of the Army Medical Service which at that time was very basic resulted in the appointment of a Commission to report on the care of the sick and wounded. It is interesting to note one member of the commission reporting: 'The Imperial Hospital at Deelfontein was far and away the finest in South Africa, just like Guy's Hospital put down in the middle of the veld.'

At first, this man, the first Dental Surgeon to treat the men of a field force only had a tent as a dental surgery. In order to do extractions the patient sat in a deck chair with his head resting against the tent pole to give some stability. He was soon inundated with requests for treatment but could do little apart from extractions until he could fit out a dental surgery with a waterproof roof. He was then given a shanty ten foot square with a tarpaulin roof into which he moved and turned it into a surgery and an office for a camp journal which he started under the title of 'The Devil's Fountain'. The shanty was later used as a mortuary!

At the end of March he had to treat a complicated jaw fracture for which he needed his 'workroom' equipment. He was then allocated a 'Hospital Shed' which he complained was very poorly constructed and extremely draughty. He converted this shed into a workroom, office and bedroom so that he could keep a close watch on all his valuable belongings. He did a lot of work on the shed to make it more habitable even to the extent of putting pictures on the walls. He constructed a plaster bench, a casting bench and a jeweller's bench with vulcaniser, lathe and all necessary appliances. This space was sufficient for two or three technicians. He had an operating room and a consulting room adjoining the main operating theatre which could be used when necessary for dental cases. Newland-Pedley ran a strict appointment system for those requiring fillings; the ophthalmic surgeon came every day at 11.30am to give gas for extractions. He wrote, 'Some surprise may be felt that one should give gas to a soldier for the extraction of a tooth and it would not be necessary if the patients were not sick, but hundreds were recovering from typhoid fever and dysentery which left them in a very weak state. A man with nine bullet wounds, who stopped a whole volley, was a very brave fellow, but he was glad to take gas for a severe extraction'.

Newland-Pedley was disappointed that the work he had to do was largely routine dentistry but he was required to treat some gunshot injuries of the jaws in co-operation with Alfred Fripp. He did observe that 'gold fillings were rarely necessary', but there were large numbers of exposed pulps. He was very concerned at the dreadful state of the officer's and soldier's teeth which meant that some of them could not eat the army food and became very emaciated. Disease, neglect, tough beef, hard biscuit and sickness played havoc with the soldier's teeth - one young man had only three useful teeth left and when the teeth have gone the soldiers have to be sent home as they are of no further use as fighting men. Newland-Pedley was surprised that some of the troops recovered from typhoid when they were in such a poor condition.

Commenting on the dental condition of the troops, an officer writing in the Pall Mall Gazette wrote, 'In the unequal struggle straining on the average biscuit, you never felt quite certain which would be the first to go your teeth or your biscuit. The doctor attached to our battalion...would extract teeth; there his duties ended; he did no filing, no filling. On the march every man was his own dentist. Exercising that resourcefulness which necessity breeds, soldiers

would plug cavities in aching teeth with tobacco, cayenne pepper, rubber (scraped from waterproof sheets) but such treatment rarely proved effective'.

Newland-Pedley was the sole dentist to look after the 5,000 sick in the Hospital let alone the 30,000 troops camped outside, and nearly all of them had very poor teeth. It was quite impossible even to relieve pain for so many men. About 2500 men were invalided home because of dental problems.

Newland-Pedley was away for six months and after his return, he accompanied a deputation to the War Office to urge the appointment of army dentists. He advocated that there should be a dental team at each stationary hospital - the other British Hospitals did not even have one dentist - and all patients requiring dentures should be sent to the base Hospital where a Principal Dental Officer would be stationed. Mobile units should be available to go to battle areas. He specified the equipment and materials that should be available. He proposed that each Dental Officer should be supported by two senior dental students. He did try and get two of the students who had volunteered to help sent out to Deelfontein. The students would bring their own foot engine and cabinet of instruments; their cost would be borne by the Hospital but the War Office refused and considered that one dentist was quite enough to care for the army of 200,000 officers and men!

The Journal of the British Dental Association in 1901 quoted from the Pall Mall Gazette, 'After twenty-one months of fighting, four dental surgeons have been sent to South Africa to attend to the teeth of the Army. Thus does the War Office put forth stupendous efforts to atone for past neglect'. The writer continues by stating that if they attend to thirty men each day, seven days a week, 'it should console a man on active service suffering today from toothache from a precious molar, which he can ill afford to lose, to know that he will not be troubled with agonising pain later than April 1907'. It was reported in a later issue of the Journal that the men of a Militia Battalion of the Cheshire Regiment had so much trouble in masticating their food that mincing machines - two per company were provided. The Lancet was very opposed to sending dentists to the front, maintaining that the army surgeons could treat all the dental problems. A grim reminder of the enteric plague which swept the country at the time is to be seen on the 200 or more gravestones in the veld near the station at Deelfontein and in fact more lives were lost through Typhoid fever than in the fighting.

His experiences in the Boer War exemplify his wonderful versatility, his great courage and endurance in facing such an overwhelming demand for his services of all kinds when he combines in himself, oral and dental surgeon, mechanic and carpenter. His plea for more dentists in the army had limited success.

Newland-Pedley resigned from Guy's in 1907 after 22 years, during 15 of which he lectured in Dental Surgery. He was then appointed Consulting Dental Surgeon to the Hospital. His colleagues and students presented him with an illuminated address on vellum which was published in the Gazette in 1908. The address read as follows:

'To Frederick Newland-Pedley Esq, FRCS LDS Eng, Consulting Dental Surgeon to Guy's Hospital. We, the undersigned colleagues and Dental students of Guy's Hospital ask your kind acceptance of the sum of £205.6.9 pence subscribed by us for the purpose of establishing a Gold Medal for Practical Dentistry as a permanent record of your valuable services to Guy's Hospitals and Schools. We greatly appreciate the zeal and energy you displayed in the foundation of Guy's Dental School. Your ability as a lecturer and teacher, and your skill and devotion to the hospital during a period of twenty two years from 1885-1907. It is our earnest hope that you may be spared to enjoy continued prosperity and good health.'

The medal was designed with his portrait on one side and the arms of the Hospital on the reverse and was to be awarded every year, although the design of more recent medals has been changed and now the name of the recipient is on the reverse. The first medal was presented to Newland-Pedley. The candidates for the award of this medal are required to select a patient and undertake the complete dental treatment. They are also required to write an essay on a given subject or on a piece of their own research work. The time limit for the exam is about six months. It is the premier prize of the Dental School and many of the recipients have gone on to distinguished careers.

Newland-Pedley wrote clearly and forcefully and stated, 'No dental practitioner can ever attain eminence in the British metropolis unless his personal qualifications are those of a gentleman and unless his publicly spoken and written utterances show him to be possessed of that minimum amount of general culture and scientific knowledge which are indispensable requisites of everyone claiming to be regarded even as an ordinary member of a learned

profession'. In these words Newland-Pedley may be said to have epitomised his own character.

In 1887 his address in the Dentists Register is given as 49 Finsbury Square, he then moved his practice to 32 Devonshire Place and from 1909 until 1944 his address was 22 Willow Road, Hampstead, which was his home.

In 1915 he was appointed Consulting Dental Surgeon to No 2 Red Cross Hospital in Rouen. It has been impossible so far to find out infomation about this Hospital. Unfortunately there was a major fire in the main archive building in Rouen in 1927 and many records were destroyed, but at the Imperial War Museum they have a record of the staff at the Red Cross Hospital and Newland-Pedley's name is included. In spite of his efforts after the Boer War to get the Government to arrange for the improvement of dental care of the troops it was still lamentable at the start of the Great War and not a single dentist went with the expeditionary force to France. He wrote of the need for army dentists and proposed an Army Dental Corps. The Lancet criticised this request but Newland-Pedley prophesied correctly that when the history of the war was written one of the features would be the prevalence of dental disorders. It is remarkable to note that in November 1918 there were no fewer than 831 Dental Surgeons in the Army serving at home and overseas. The Army Dental Corps was not formed until it was authorised by Royal Warrant in 1921, the Special Army Order being signed by Winston Churchill on 11 January 1921.

In 1916 he married Octavie Gertrude Bernadine Therese, daughter of Nicolas Gathy of Liege, Belgium. They did not have any children and his wife died of cancer when she was about forty five years old.

Newland-Pedley was twice Open Golf Champion of Belgium.

He was awarded the Honorary Fellowship of the British Dental Association in 1930 but was unable to be present. Also honoured on that occasion was Bernhard Gottlieb from Vienna.

Newland-Pedley with Italian family

Newland-Pedley was a great traveller and visited many parts of the world. One of his favourite countries was Italy and he had the idea to live there for some years, and with this in mind he

had taken lessons in Italian. In 1930 he was talking to some people and asked them if they knew of a quiet family hotel in Italy. They told him about the Hotel Miravalle owned by the Scheininis in Grandola near Lake Como. He went there in 1930, and according to the account given by Mr Leas Read the then Clerk to the Governors, he arrived there as a sick man. He was nursed through his serious illness by the owners of the hotel. He made a good recovery and said that he had not felt so well for many years and wanted to stay in Italy for the rest of his life, which he did. At the end of the season the Hotel was closed to visitors but Newland-Pedley asked if he could stay through the winter and live as one of the family and this was agreed by the owners of the Hotel.

Senora Germano the niece of the owners of the hotel knew Newland-Pedley very well. She came to visit Guy's with Mr Burfoot, the former Clerk to the Governors, in 1988 and I visited her in Como last year. She was able to provide a lot of information about Newland-Pedley's life in Italy.

His life at Grandola was very happy. He had a gardener for himself who made a putting green on the lawn so that Newland-Pedley could practice every day. The gardener also planted many flowers, especially roses, camellias and tulips which were enjoyed by all the visitors to the Hotel.

Church at Acquaseria

In 1937 there were few visitors to the hotel because of the political situation; the owners sold the Hotel and Newland-Pedley purchased a small villa near the Church in Acquaseria. (In return he promised to provide for their future which he did by the annuities granted in his Will). The villa, where he was the sole guest was purchased in the names of the Scheininis because if it was in his name he would not be able to leave the house to them as he was a foreigner. Newland-Pedley installed a bathroom and central heating. Later he bought another house near the Miravalle Hotel in Grandola.

A larger house in Acquaseria then came on the market and Newland-Pedley bought this in the names of Senora Germano and Senora Guiseppina Scheinini and again installed a bathroom and central heating. It was only in the names of two people

because under Italian law whenever an owner died tax had to be paid on the property.

They spent the summer in the coolness of Grandola and the winter in Acquaseria.

He became a great benefactor of the village of Acquaseria and could be described as the patron of the village. After the Abyssinian War the soldiers came back and had no work. Previously many had employment in Switzerland but Mussolini would not allow Italians to work abroad. There was therefore great hardship in the village. The local Curee had for years been trying to save enough money to build a good church in the village but had only been able to build the foundations: he existed on bread and cheese to save money. Newland-Pedley said that he would pay for the work to be done by the villagers, Every able bodied man was to do a full weeks work in quarrying the stone, moving it to the site and erecting a building. The result is a beautiful stone Church built on the side of the hill in the village. Although there is a plaque commemorating Newland-Pedley's gift he did not want it placed in a prominent position and so in fact it is to be found behind the altar. The inscription on the plaque is in Italian and reads:

'This Church was built from the generosity of Mr Newland-Pedley guest at Acquaseria of the family Beltramo Scheinini. It was opened for services 3 July 1937'.

The Church is simple inside but contains very attractive furnishings and some pretty stained glass. The main altar was moved from the old church. The new Church cost approximately £1,500. Newland-Pedley was a great benefactor to the children in the village. He established such respect and affection that he was able to go out at will in safety even though there were many rough people roaming the country.

He maintained regular contact with London as his major-domo and wife kept his house in Willow Road ready for him. The butler sent out a newspaper every day and Newland-Pedley also had his suits, shoes and other clothes sent from London. He even stayed on the Dentists Register although he never did any dentistry in Italy.

Unfortunately he never thought that there would be another World War and refused to make any financial arrangements although the Manager of the bank in Menaggio advised him to have a reasonable amount of money transferred from England. Newland-Pedley refused to believe that Mussolini would enter

the war against Britain. The result was that when war broke out he was unable to get any further money from home and was left with only a very small allowance permitted by the Italian Government from the Swiss Red Cross which was soon stopped. He was then maintained by the people he had befriended and they also had to meet the expenses of his funeral.

When the Church he had built was consecrated, the Bishop of Como conducted the Service and Newland-Pedley invited him, the priest and other important guests to a splendid lunch prepared by the Scheininis. Senora Germano was also present. During the lunch the Bishop thanked Newland-Pedley for his generosity as he was not even a Catholic but a Protestant and he offered his protection at any time. This offer was invaluable as during the war the Bishop was able to prevent Newland-Pedley from being sent to a concentration camp or from having to report to the police daily, since Acquaseria was near the Swiss border. As a result Newland-Pedley was left alone and no restrictions were imposed on him, although Mussolini had issued an order that no foreigners were to live near the border.

During his stay in Italy Newland-Pedley changed his Will many times. The last time he changed it he did not send it to London before war was declared. His Italian solicitor who was a life long friend of Senora Germano put it in his safe in Como for two years. Then the BBC announced on the radio that Como was to be bombed by the Allies. The solicitor contacted Senora Germano and advised her that the Will should be taken to Grandola; she did this, and her uncle put the will in a metal box and buried it in the garden of the Villa and there it stayed until 1944. At this time there was a lot of local trouble. The Fascists had occupied the Hotel Miravalle and were being attacked and killed by the partisans. Therefore the Fascists placed mines all round the hotel grounds and one Fascist Officer had his foot blown off by one of these mines very near the Villa.The Will was therefore not safe and so it was dug up and Senora Germano came from Como and took it back to the Solicitor who kept it till the end of the war in his safe.

Towards the end of his life Newland-Pedley asked to be buried in the Scheinini grave in Santa Maria Rezzonico, the next village to Acquaseria. When he died on May 4 1944 the German Commandant would not allow his body to be moved from Grandola to Acquaseria as they were in different communes and so the family obtained permission from a local family to put his body temporarily in their grave and then after the war he was moved to the

family grave in Santa Maria Rezzonico where he rests to this day. As Leas Read recorded: 'Guy's men have been responsible for many things from time to time, but it must surely be unique for one to found a school in his own country and to build a church in the country of his adoption'.

After the War Newland-Pedley's solicitor in London wrote and asked about the Will and Senora Germano answered all his questions. It could not be sent to London until the British Consulate reopened in Milan. Senora Germano went to Milan with the Solicitor from Como and the Will was opened and read. They wanted to send it straight to England by plane but as the planes were not very safe the solicitor took the Will back to Como and made a copy of all the pages, certified that they were true copies and then they both went back to the Consulate and the Will was sent to London.

The London Solicitors sent the Will to Leas Read, the Clerk to the Governors and there were difficulties in obtaining probate as Newland-Pedley died when he was domiciled in enemy territory. It was therefore necessary for Leas Read to go to Switzerland to meet Senora Germano to try and sort out the problems as there were legacies left to the people in Italy who looked after Newland-Pedley. Leas Read went to Lugano and met Senora Germano to discuss the Will. It was then necessary for the Senora to come to London to see the Solicitors and to make arrangements for the legacies to be paid.

In his Will, Newland-Pedley left the bulk of his estate to Guy's Hospital in commemoration of his connection with the Dental School and to be applied to the endowment of existing Prizes and Scholarships or to the establishment of others in connection with the Dental School.

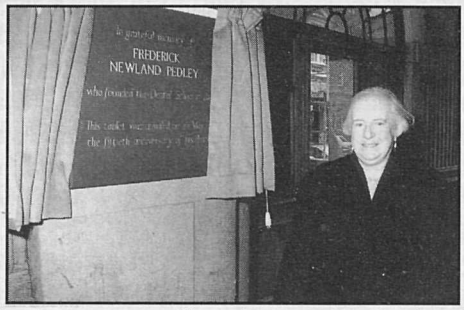
The School has benefited enormously from this bequest and funds have been used to send staff to conferences, to provide scholarships to staff to teach in the Dental School, to support Dental Research in the School, to assist with student electives and currently plans are in hand to establish a Newland-Pedley Chair for Dental Research.

As Doubleday so elegantly put it, 'Every Guy's man should stand hat in hand and pay tribute to his memory'.

Newland-Pedley was a remarkable man in many ways. He established the Dental school at Guy's, he was very concerned with dental education and the provision of dental care for the poorer people in the community. His experiences in the army led him to campaign hard for the establishment of the army

dental corps. He then went on to establish a great name for himself in a small community in Italy.

A plaque to his memory is to be found in the Colonnade at Guy's and this was unveiled by Senora Germano on the 4 May 1994, the fiftieth anniversary of his death.



Iolanda Germano unveiling plaque to Newland-Pedley in the Colonnade - May 1994

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A H R Rowe

Anaesthesia in Wonderland

The beginning of the big sleep

A clergyman tells me that the proliferation of medical programmes on television could be causing his young pupils some confusion. 'What is an atheist?', he asked a group of 12-year-olds. 'He's someone who puts you to sleep before an operation,' came the crisp reply. A few years ago, I was taking a history from a young child and enquired whether she had ever had an operation or an anaesthetic. 'Yes,' she said. 'What was the anaesthetic like?' I asked. 'Oh, he stuck a needle in my arm and I simply disappeared.' I think this young lady had got it exactly right.

Anaesthesia officially started on Friday 16th October 1846 when William Thomas Green Morton, a dentist, gave a public demonstration of sulphuric ether at the Massachusetts General Hospital in Boston for the painless removal of a tumour from a patient's neck. It was an outstanding success and the news spread fast. Professor Jacob Bigelow witnessed the demonstration and wrote to his expatriate friend and colleague, Dr Francis Boott, who was living in London. Boott arranged with James Robinson, a neighbouring friend and dentist (who registered as a student at Guy's in 1831), to carry out their own experiments with ether inhalation. The first use of ether in the United Kingdom was on Saturday 19th December 1846 when James Robinson administered it to Miss Lonsdale, who was Boott's niece, in the presence of Boott and his family in their private house at what is now number 52 Gower Street. It is only in recent years that this successful administration of the first general anaesthetic in this country has been properly documented, largely due to the

"What is an atheist?' he asked a group of 12-year-olds? 'He's someone who puts you to sleep before an operation,' came the crisp reply.'

efforts of Dr Richard Ellis of St Bartholomew's Hospital (1). A public demonstration followed on 21st December at what is now University College Hospital when Lord Liston amputated the leg of a butler, Frederick Churchill. The anaesthetist on that occasion was William Squire, a medical student.

James Robinson had a large and successful practice in London and was recognized as one of those very few dentists who performed their work in a strictly professional manner. At the time dentistry was entirely unregulated, had no professional structure, training or standards. Robinson soon gained a reputation as the most skilful administrator of ether anaesthesia in the country, and was called in to anaesthetise patients when the attempts of others had failed.

Crawford Long, a country doctor in Georgia USA, was in fact the pioneer of the use of ether, which he first administered on 30th March 1842, but he did not publish his work until 1849. The reasons for his delay are not fully understood but he was working in difficult circumstances and the public at that time was hostile to new ideas. Horace Wells, like Morton also a dentist, pioneered the use of nitrous oxide in his practice before the introduction of ether by Morton, but was unable to give a successful public demonstration of its effects.

The invention of general anaesthesia thus opened the door for the modern era of surgery. Chloroform was introduced through the efforts of Sir James Young Simpson, Professor of Midwifery in Edinburgh, who noticed its effects in after-dinner frolics. Simpson used chloroform to relieve the pains of childbirth but soon ran into a lot of hostility on biblical grounds. It was only when Queen Victoria inhaled a few drops of chloroform (2) from a handkerchief as a method of pain relief during the birth of Prince Leopold on the 7th April 1853 that the religious scruples of the day were overcome. The Queen was attended by Dr John Snow who was the first professional anaesthetist in England and a notable epidemiologist - he showed that cholera was a water borne disease. She gave warm approval - 'Dr Snow gave that blessed chloroform and the effect was soothing, quieting, and delightful beyond measure.' He was also present when the Queen again took some chloroform, as a means of analgesia not anaesthesia, for her ninth confinement on 14th May 1857 during the birth of Princess Beatrice. Snow encountered a problem here because Prince Albert had previously taken it upon himself to administer some chloroform from a handkerchief to his wife. This emphasises one of the

perennial problems with anaesthesia; it can look so easy that almost everyone thinks they can undertake it. These royal occasions made anaesthesia in midwifery morally respectable and the method was termed 'chloroform *à la reigne*'.

Chloroform, like most anaesthetics, is an extremely dangerous drug. Its liability to cause sudden heart failure didn't become apparent until 28th January, 1848 when Hannah Greener a 15-year-old child died during its administration whilst having an ingrowing toenail removed. A marginal note to the entry in the Register of Burials for the Parish of Winlaton, County Durham for her death states, 'Died from the effects of chlorifom *(sic)*'(3). Not unnaturally it took a long time before chloroform enthusiasts could be convinced of the truth of the seemingly impossible - that too small a dose could kill. Every week the medical journals reported sudden deaths under chloroform for trivial operations. It was not until 1911 that Goodman Levy, a Guy's man, provided an explanation with his classic experiments with adrenaline during light chloroform anaesthesia. Dr John Snow writing in the *British Medical Journal* in 1858 commented that 'the medical officers of Guy's and St Thomas's Hospitals had a strong objection to narcotism by inhalation for the first two or three years after this practice was introduced, and chloroform was used much less frequently in these institutions than in the rest of the hospitals in London; yet it was in those two hospitals that two deaths from chloroform occurred before any such accident had happened in any other hospital in this metropolis' (4).

In the modern era, Malcolm Fisher, the Australian anaesthetist, defines anaesthesia as:

the half asleep,

watching the half awake,

being half murdered,

by the half witted.

The novelist, Richard Gordon, author of the *Doctor in the House* books, didn't help the image of the anaesthetist either. His real name is Dr Gordon Ostlere and before he took up writing as a full-time occupation he served as

First Assistant to Sir Robert Macintosh in the Nuffield Department of Anaesthetics in Oxford. No one seems to be able to forget the portrayal of the Richard Gordon novels on the cinema screen with comments from the surgeon, Sir Lancelot Spratt, to the anaesthetist such as, 'If the patient can keep awake at my end why can't you at yours?'

'A surgeon once said, 'I can kill a patient in a few minutes: you (the anaesthetist) can do it sooner.''

Anaesthesia is the largest single hospital specialty in the National Health Service. Modern anaesthesia relies on sophisticated technology and anaesthetists have often been compared with civil aviation pilots. The duration of anaesthesia training, after preregistration and usually six months to a year's experience in other fields, will reduce to six years when the Calman proposals are implemented. A surgeon once said, 'I can kill a patient in a few minutes: you (the anaesthetist) can do it sooner.' Another wrote, 'There may be minor operations but there is never a minor general anaesthetic'(5). Anaesthesia in developed countries is now remarkably safe. A study of anaesthetic mortality in 1982 estimated the risk of death as 1:10,000. This report led to the establishment of a series of reports called the *Confidential Enquiries into Perioperative Deaths* (CEPOD reports). The first report in 1987 attempted to separate out the risk due to surgery and it has been calculated that the risk solely due to anaesthesia is about 1 in 185,000 anaesthetics. However, studies in Leiden and in the USA show a risk of a cardiac arrest during an anaesthetic as 0.6 and 0.9 per 10,000 respectively (6). Accurate figures for less developed countries hardly exist but deaths due to poor anaesthesia administered by inexperienced personnel are frequent. I was given a figure by a news reporter of some 3 per cent for hysterectomy in rural parts of some Asian countries: in these areas patients are quite understandably terrified and don't want to be operated upon.

'Anaesthesia in developed countries is now remarkably safe.'

'Anaesthesia' in the medical curriculum offers the student an almost unique experience of a one-to-one relationship in the clinical setting with great emphasis on acquiring a variety of 'hands-on' practical skills which will be

vitally necessary upon qualification. The days when a newly qualified doctor could tear open someones belly to remove an inflamed appendix have gone; so it is with anaesthesia. The skills taught in the undergraduate curriculum (7) during the attachment to 'anaesthetics' emphasise many factors in the care of the unconscious patient, maintenance of vital life functions, care of the patient before and after operation, the provision of pain relief both acute and chronic, knowledge of the use of clinical monitoring devices, maintenance of acid-base, fluid and electrolyte homeostasis, knowledge about oxygen therapy, communication and health care management skills of the acute services. Furthermore, there is the opportunity to observe how drugs, blood loss and transfusion affect normal physiology and pharmacology plus an insight into intensive care, the problems of children and aspects of trauma.

When Alice went down the rabbit hole and disappeared she never considered how in the world she was going to get out again (8). It is worth remembering just what is the problem of getting out of a hole like an anaesthetic without the patient being permanently damaged, or dying, in the process. I can imagine nothing worse than for a perfectly healthy patient to die or become disabled as a result of an 'anaesthetic accident'.The cost to the family and to society can be astronomical. Medical negligence claims are rising yet again and this will surely get worse now that the Lord Chancellor is proposing to introduce into Great Britain a 'no win no fee' contingency for lawyers as exists in the United States of America. Anaesthesia is a 'sharp end specialty' and the anaesthetist has to live in real time: he or she is not like the physician who can come back with an answer hours or days later. The specialty in the UK is physician based and emphasises the importance of diagnostic skills as well as the technological aspects. Anaesthesia is arguably the most important subject taught in the undergraduate curriculum (9). The cost of an anaesthetic is a matter of a few pounds - trifling amounts compared with the bill for antibiotics, chemotherapeutic agents and a host of other hospital services. I sometimes wonder whether present cost-cutting measures in the UK will mean we shall have to go back to chloroform and ether: after all, the cost of dealing with jaundice as a result of delayed chloroform poisoning will come from someone else's budget.

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Anthony P Adams

The First Heart Transplants in the United Kingdom, 1968 - 1980

The Role of Guy's Graduates

This is the third and final part of the Gazette feature on Heart Transplantation.

Renewed Interest in Heart Transplantation - the Papworth Programme

In 1978, after completing my general and cardiothoracic surgical training, I hoped to find a post in academic cardiothoracic surgery, but no such appointment was forthcoming. However, I was offered the opportunity of a locum senior registrar post at Papworth Hospital for one year (extended for a second year) as the incumbent was spending time in the USA. I was very pleased to be able to return to Cambridge as I had a great love of the city and enjoyed working at Papworth, where I had been a registrar some years earlier. It also gave me the opportunity of pursuing a subsidiary interest as a Fellow of Magdalene College, where I was Director of Studies in Medical Sciences and supervised in anatomy.

At Papworth, Terence English (who graduated from Guy's in 1962, and is now Sir Terence) confided in me that he was planning to start a heart transplant programme there. The results at Stanford University in the USA, which centre Terence had visited, had slowly improved, and he believed the time was opportune for a centre in the UK to enter this field again. I had also visited Stanford a year earlier, at which time I had seen a heart transplant performed. My return to Papworth was therefore a wonderful opportunity to be involved in the clinical development of a form of surgical therapy in which I had long had an interest.

We prepared ourselves to some extent for the clinical heart transplant programme by carrying out a series of experiments on storage of the heart, involving orthotopic heart transplantation in pigs (11). This work was carried out at Huntington Research Centre, situated in a remote and desolate site in the Fens between Huntington and Ely. As Terence did not want the research programme to interfere with the growth of the routine clinical surgical activity at Papworth, some of these experiments were begun before 7.00 in the morning. I well remember the considerable discomfiture of getting out of bed in the depths of an East Anglian winter and driving in the dark and cold (on an empty stomach) to what appeared to be the back-of-beyond before I was even fully awake. My interest in surgical research was tested to the limit.

During the course of 1978, several patients were referred for transplantation. Some had major contraindications and others sadly died before a donor heart became available. Towards the end of the year, however, a relatively stable patient spent several weeks waiting in the hospital. I can well remember having Christmas lunch with him and other patients in the ward. Early in January 1979, a potential donor became available one Sunday morning, and the surgical team was called in.

The patient was administered prophylactic antithymocyte globulin (ATG) and soon developed increasing haemodynamic instability. Whether or not the ATG was a factor in his instability, I shall never be certain. I drew his deteriorating haemodynamic status to the attention of Terence English who was about to leave with John Shaw, one of our registrars (and a Guy's man), to retrieve the donor heart at Addenbrook's Hospital. He recommended that we get to the operating room as soon a possible.

I and another registrar scrubbed whilst the patient was anaesthetized. Evidently, there were some episodes of hypotension during the induction of anaesthesia but by the time the patient was brought to the operating room he appeared to be relatively stable. We opened the chest and prepared for cardiopulmonary bypass, but, as he remained stable, did not initiate bypass immediately as no word had yet that the donor was on its way to us. The blood pressure suddenly fell significantly so we immediately initiated cardiopulmonary bypass and stabilised the situation.

Terence English returned with the donor heart and I assisted him inserting it. The operation was technically successful and the heart functioned well. We left the operating room in high spirits, but it soon became of concern that the

patient did not appear to be waking from the anaesthesia. By the following morning it was clear that he had suffered some degree of brain injury. As the next few days passed, it became certain that this injury was serious. He never regained consciousness and, when he died after 17 days, an autopsy showed severe brain damage which we presumed (although could never confirm) was related to his immediate pretransplant episodes of hypotension, although the length and degree of hypotension the patient experienced did not seem significant enough to cause such severe permanent injury. Other causes, such as air emboli, could not be definitely excluded, but there had been no incident during the operation that made us suspect such a complication.

As would be expected, considerable publicity was associated with this first UK heart transplant after so many years, and we were all naturally exceedingly disappointed that it had not been more successful. Terence English handled the press and publicity with caution and dignity.

It was more than 6 months before we had an opportunity to carry out a second attempt. In the meantime, considerable discussion took place between Roy Calne and Terence English as to whether cyclosporine should be utilised in these cases. The experience with cyclosporine at that time was very limited, but Roy, who had introduced it into clinical practice, had great faith in its efficacy. Terence, on the other hand, felt that we should continue to base our protocol on that of the Stanford group (who had not yet used cyclosporine) and not introduce another relatively untried factor at this early stage of our programme. We therefore did not use cyclosporine during these early attempts.

In August 1979, we had the opportunity to perform our second heart transplant at Papworth. Fortunately, the second patient did much better than the first. Once again, Terence went himself to procure the donor heart and I and one of my colleagues began the recipient procedure. When Terence returned with the donor organ, I assisted him in its insertion. (In a previous short article (13), my recollection was that Roy Calne joined us to participate in this operation. Since then, however, Terence English has reminded me that it was at the third heart transplant that Roy was present.)

The surgical procedure was successful and the patient did extremely well for many years, becoming a well-known and popular symbol of the success that organ transplantation can bring. He was a cheerful Londoner and proved to be a great public relations man, not only for Papworth Hospital, but for organ

transplantation in general. His personality did much to establish public support for heart transplantation in Britain at that time.

We performed a third heart transplant at Papworth during 1979 (at which Roy Calne participated), which was again successful and, very early in 1980, I assisted at my final transplant at that centre before taking up a post in Chris Barnard's department at the University of Cape Town. This early clinical experience at Papworth was subsequently reported in the medical literature (11).

Comment

I was extremely fortunate to be able to participate in all of these early attempts at heart transplantation in Britain. Although only a very peripheral observer of the first two cases, nevertheless, they added greatly to the excitement of life and proved a great stimulus to a junior surgical research fellow. My involvement in the establishment of the heart transplant programme at Papworth did much to consolidate my interest in this field of surgery and, indeed, from that time on it has been my major clinical and research interest.

The role of Guy's 'men' in the development of heart transplantation in the United Kingdom is therefore quite remarkable. Early experimental work was carried out in Brock's laboratory at Guy's and by Donald Longmore's group at the Royal Veterinary College. Although Donald Ross is not a Guy's graduate, he was initially research fellow and then senior registrar and subsequently a consultant colleague of Lord Brock at Guy's and, after Brock's retirement, headed the Thoracic Surgical Unit for many years whilst also holding the senior surgical post at the National Heart Hospital. Donald Longmore and Jane Somerville are Guy's graduates. After graduating from Guy's, Roy Calne, Terence English and I were all, at one time or another, house officers under Brock and Ross at Guy's. John Shaw, now a renal transplant surgeon in the West Country, is also a Guy's graduate.

The first two heart transplants in the UK were, therefore, performed by a Guy's surgeon, the third performed at Guy's Hospital and, after a delay of several years, the definitive programme at Papworth Hospital was initiated by another Guy's graduate. At both the National Heart Hospital and at Papworth, the surgical, medical and research teams contained a number of other Guy's men and women.

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David K C Cooper

Beyond the Textbook - An Insider's Guide to Journals for Students

Even with the GMC guidelines for the future of medical education the factual content of the knowledge required by examiners has not really been reduced. The textbook is the natural source of these seemingly addictive facts; the reviews section of the Gazette sees many good and bad textbooks each month but there must be a time when everyone, from doctor down to the lowest medical student, tire of even the best text. What happens when the books are left on the shelf?

There are a plethora of journals in medicine and with special versions aimed directly at the student market. While many of the lock, stock and barrel medical journals lead the way in reporting research in many specific fields they are not always directed towards the student. The more general journals such as the *British Journal of Medicine, The Lancet, The New England Journal of Medicine* and the newly formed *Nature Medicine* include excellent reviews often read by students, but they are not directly aimed at them. This is an introduction to some of the journals produced for students.

First is the Student BMJ. This is the younger brother (or sister) of the BMJ and is the market leader in the student journal group. It is available to student members of the BMA and is delivered to your door. It contains a selection of the papers and articles from the big BMJ as well as original articles directed at students. It is published once per month and each issue draws on the previous four BMJ's and the contributions from medical students. Extracts from the successful BMJ 'ABC Guides' are the mainstay of the educational content. The sections on News and Student Politics, Student Life and Letters are almost entirely student written. The Letters section invites contributions from students on all aspects of life as a medical student and attempts to act as a forum for opinions; the Student Life section includes interesting articles on careers and medicine in other countries, although the quality of some of the articles is questionable. Overall the **Student BMJ (ISBN 0966 6494 BMJ Publishing Group)** is one of the best journals for students.

The Medicine Group's educational journal originally entitled Medicine is also a useful aid to medical students. One problem with textbooks is that often as soon as they are published they become out dated. Does this guaranteed obsolescence ensure the publishers pockets are never empty or is it the result of the rapid advance of medicine? A good question! Also, in some of the larger all encompassing books there may be errors, compounded by the large amount of copying from other

existing books that may occur when they are being written. Students will always use the larger textbooks but they can get the up to date picture from journals such as Medicine. This journal is produced in full colour twelve times a year; the editions are centred on specific topics and a topic may be covered in full over two or three monthly editions. The recent editions have covered renal and liver disorders. These topics are very well presented and include clear diagrams and photographs from specimens and to X rays! This series, **Medicine (ISBN 1357 3039 The Medicine Publishing Group)** available at discounted rate to medical students, is both well produced and written.

Other journals are also available for students and are worth a mention. These include **Surgery (ISBN 0263 9319 The Medicine Publishing Group)**: a not quite so good relation of Medicine; the **Clinical Training Updates** and **Clinical Exam Cards** (with a superdooper binder included with student MPS membership) and also **Hospital Update (ISBN 0305 4136 Reed Elsevier).** These may have useful articles for medical students as well.

Consider looking at a journal when you get fed up with textbooks - they are not so heavy and might even be interesting!

Richard Littlewood

Guy's Hospital Dental Society Annual Clinical Day

March 4th 1995

Meteorologists should take note of the first Saturday in March. Clinical Day, for so long as I can remember, has been cold and blustery with the Colonnade taking on a secondary role as a wind tunnel!

In this respect, 1995 was no different and the weather conditions in other parts of the UK may have accounted for the slightly lower attendance figures than last year.

The proceedings started in the now customary fashion with the Herbert Memorial Lecture, this year's being the fourteenth in the series, delivered by Mr Nicholas Capp. His title was 'Restorative disasters - do we need practice-based specialists?'

Professor Frank Ashley, Dean of the Dental School, welcomed Nick Capp who qualified at Guy's in 1979, subsequently studied in Michigan, where he obtained his MSc in 1983 and completed FDS and MRD on his return to this country.

This well-illustrated presentation started with a brief look at the politics of practice-based specialists but concentrated its main thrust on many clinical cases seen by the presenter in his practice.

Restorative dentistry was covered from A to Z with cases involving crown and bridgework, removable partial dentures, implants and fillings.

The vote of thanks was given by Professor Bernard Smith and enthusiastically endorsed by the capacity audience in the Tower Lecture Theatre.

Following the lecture visitors were encouraged to view the presentations on Floors 21 and 22. As in past years, these included work of current students, staff (from clinical and scientific departments) and alumni. In addition there were 13 trade stands exhibiting the latest in surgery equipment, sundries and laboratory techniques.

In the Tower Lecture Theatre at 12.35pm, Professor Ashley introduced the traditional 'Cases you have sent' lecture. Delivered this year by Mr Don Gibb, this presents a review of interesting cases seen by the speaker in recent clinics. The audience was treated to a very wide selection of clinical material from all types of trauma, orthognathic surgery, uncommonly seen pathology as well as more routine cases presenting to an Oral Surgeon.

Following this presentation, Mr Paul Robinson gave a vote of thanks on behalf of the large audience.

Between the lecture sessions, presentations consisting of a wide range of activities from the Dental Hospital and including poster and table demonstrations, and the display of new items of equipment in use, were displayed on Floors 21 and 22. These included a

surgical laser, shade taking using colorimetry and spectrophotometry and the use of a newly developed lithotripter for the treatment of salivary stones. Other presentations included details of the new prosthetics technical course, osseointegration and facial prostheses, computerised collection of data using bar codes, cleft lip and palate treatment and an insight into the new Dental Polyclinic at St Thomas'.

The prizes for the Clinical Day presentations this year were awarded to Mr Allan Thom for his 'Cleft lip and palate - from birth to maturity' and Mr Derek Spiller and Mr Steve Marsh for 'Why a new technical course.'

Any report on the activities of Clinical Day would be incomplete without mention of the Dental Dinner. This year new ground was broken with a rather more informal style event, held in the Roben's Suite on the evening before Clinical Day. Organised by Nigel Fisher, Guy Palmer and Eric Whaites, the event was well oversubscribed with numbers being limited to 100 by the available accommodation. A buffet style meal was well received and enjoyed by all present followed by a toast to the Dental Hospital and School proposed by Eric Whaites and replied to by Professor Frank Ashley. Following the toasts, Nigel Fisher said a few words about the new format of the event and then invited Edwina Kidd to draw the raffle.

Overall a good meeting despite the slightly reduced numbers which as usual was organised with customary efficiency by Laurence Usiskin assisted by an ever willing band of undergraduate stewards.

Paul N Sheppard
Senior Clinical Lecturer
Department of Oral and Maxillofacial Surgery

Peter Frost and Gary Sinclair with their poster showing a novel reservoir for artificial saliva in a denture

What's 3% of Virginia Bottomley?

Who's afraid of Virginia Bottomley? Now that Guy's has secured some sort of a stay of execution - although as poor Nicholas Ingram in Georgia USA found out, such a relief is not necessarily permanent - there is less fear of Mrs Bottomley now. Though it remains to be seen whomever Mr Blair appoints to be her successor, if Labour forms the next administration, looks more kindly on London's health arrangements. Indeed I wonder whether Mr Blair may not secretly hope that arrangements are so far in hand, that he may have no opportunity to reverse decisions, and avoid a fresh round of problems!

But for the moment nurses, nationally and locally, are more concerned about the pay round currently being laid down by Mrs Bottomley, and about which she refuses to indulge in further discussions. Guy's & St Thomas' Trust has allegedly, subject to ratification by its Board at a future meeting, and with strings attached - goodness how much more can be fitted in this sentence before readers can relax to hear the announcement? - is offering its nursing and midwifery staff 3.25%.

This is above expectations made by the Review Body; it must make nurses and midwives less concerned about Mrs Bottomley, and glad they work for a Trust which is generous. Of course, we all know that when the Government set up Trusts, it was with the proviso that they would have a degree of autonomy and an ability to set up local pay bargaining, as I have written in this column on a previous occasion.

This diversion from national rates is not a debut for Guy's: when it was a part of the Guy's & Lewisham Trust - remember Mr Major's flagship? - some low paid clerical and ancillary staff were offered special bonuses. Apart from some 'A' grade staff, nurses were not paid lowly enough to come within this category. So, working at Guy's or St Thomas' may offer a financial advantage now, compared with other staff in nearby operations. Is this along the lines of dividing and ruling a workforce, do I hear?

There has been widespread protest about nurses and midwives pay, firmly supported by the Royal College of Nursing and Unison; the Royal College of Midwives has voted and rescinded a no strike rule. I hope that they, and nurses, will not strike. I think such action would permanently tarnish the image we have, of what is, pre-eminently, a profession that is all about 'care'.

I have never liked the notion, which anyway seems rather out of fashion now, that nursing is a vocation. From my own point of view, this implies someone has 'called', though semantically the word may have a different connection to most people. Neverthe-

less, striking hits at those for whom we are trained to care, and where are they to find an alternative? Few of those around us in South London can afford private healthcare - indeed many are deprived and unemployed.

This is not to say that the Government should be able to get away with this issue. Nurses and midwives are only guaranteed a 1% rise, unlike their medical colleagues. The cost of living has risen more than this; the Government hopes local conditions will mean that all nurses can gain a 3% increase. Unless we are recognised as members of a national health service, fears are fuelled that either by design or default, the present regime is dismantling so many aspects which have formed the NHS, that it may fall apart.

The pages of the nursing press have been full of stories from nurses who, are sacrificing their standard of living to remain in the profession. The Government should not expect job satisfaction to be sufficient reward. There are too many instances of greed being fulfilled, while need is ignored. For nurses to care, we must demand that Mrs Bottomley, with the Government, also show some sign that they care for nurses. There have been too few signs of this recently.

Denis Cobell

Rugby

Guy's Hospital 3rd XV (18) v St Mary's (8)
Hospital Cup Final, Old Deer Park, 15 March 1995.

It was a 'psyched up' 3rds team which met in the Spit at 10 am on this special Wednesday morning (especially Christian with his Rocky films and tapes). On arriving at Old Deer Park, with 'Eye of the Tiger' still ringing in our ears, it felt strange to be clutching our rugby kit and not a bottle of Cockburns. Nevertheless, half the team went to look at the grassless pitch, the other half started to get changed. This left Big Rich, who had done his usual trick of forgetting an item of kit, this time his shorts. So, while Ed and Rich searched Richmond for a 'large' pair of shorts, the rest of us got even more psyched up for the imminent game!

The first half was a close contest, played in radiant sunshine with a great atmosphere (mainly from the Mary's vast entourage of support). After beating Charing X in the semi-final, 57-0 (Christian and Smokey both scoring a hat-trick of tries), we were brimming with confidence; but then Mary's had disposed of the London, 51-0 in their semi-final! It was evenly matched in the opening quarter with Mary's ahead with a penalty, and I thought they were slightly ahead at this stage. However, Mary's infringed on their 22 yard line and Kier reduced our worries by kicking over. No more points were scored to leave the half-time score 3-3.

In the second half we started better and with a dominance in the lineout, which we have enjoyed all season, due to Tony 'too tall' Rose and Andy Bates, we were on top. However, it was from a scrum that we scored our first try. The ball came back to Miles 'Tyson' Walkden (who is vying against George for the thinnest legs at Guy's competition) who 'flew it' to Kier. The ball continued down the line to Scotty Simpson, who broke the tackle, to go over for a great, but surprisingly soft, try. Guy's were clearly dominant now and won a penalty on their 22. We decided to run it - true Guy's tradition - with Miles tapping and passing to Waz. Waz charged into the defence and with the ball quickly ripped, was passed onto Big Rich on the charge. After a nimble side-step, a la Phil Bennet, Rich thundered over the line for the largest try of the day! With the score now at 13-3 to us, we again won a lineout. This time it was Christian who caught it and charged through the line towards the defence. Christian, having been stopped, looked for support and found me wandering around near him to whom he passed and I managed to cross the line from 5 yards out. This made the score 18-3 and we were determined not to let it slip. Although Mary's came back at us strongly and scored a try, they ran out of time, leaving us champions by a score of 18-8.

After the game, and after eventually finding the Cup (thanks Pete), we retired to the London Welsh bar.

All in all, no dents, no memory, but a great day! The only slight disappointment was that maybe a few more people could take a half day off from the library/lab/other excuse and come and watch - even just to enjoy the sunshine and atmosphere. I assure you that you would enjoy it! It was a disappointment to the team that the acting Rugby President could not come to watch and enjoy the day and see why we are so proud of being 'The Oldest Rugby Club In The World!'

The Glorious Champions are: 'Big' Rich Clinton; Waz 'notso' Slim; Darren 'Pom king' Jones; Tony 'too-tall' Rose; Andy Bates; Andrew 'Pit Pony' Williams; Christian Smith; James 'viva' Dinsmore; Miles 'Tyson' Walkden; Kier 'greatboot' Lewis; Smoky 'small quick bloke' Darwish; Pete 'Johnny Spence' Morgan; Scotty 'Bart' Simpson; Shay 'return to' Reading; Mark 'bigboot' Lewis.

Also, thanks to Chris 'married' Marshall - sub; and not forgetting Mark 'Idiot' Blunden - touch judge. Many thanks also to those supporters that did turn up.

Andrew Williams

Memorial Service

A memorial service for Virginia Hartley, Sister, Oral Surgery Day Case Unit 1982-95, who died on 3 April 1995, will be held at Guy's Hospital Chapel on Friday 9 June 1995.

Apology

In the April issue, we incorrectly reported the passing away of Panis-Piper, R F. This should have read **Parris-Piper**, R F died 30 January 1995. We offer our sincerest apologies for any distress caused.

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Old Students' Day 1995

This year's Old Students' Day will be held on Friday 8 December on the St Thomas' campus. As last year, Guy's old students will be invited to attend and it is hoped that as many as possible will be able to do so.

Edgar Sowton Memorial Lecture

The Edgar Sowton Memorial Lecture will be held on 8 June in the Tower Lecture Theatre, Floor 30, Guy's Tower at 5.30pm. It will be given by Mr John Parker and will be entitled 'A Journey Paced and Ballooned'. For further details contact Mary Bonner at St Thomas' (0171 928 9292) ext 2253.

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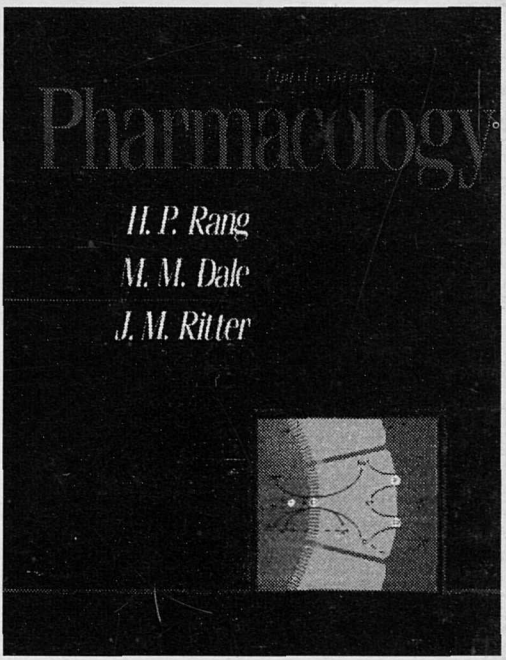

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Passim

During the last two years the Gazette has watched anxiously events concerned with the merger of Guy's and St Thomas'. We have reported and commented upon a strange series of activities observed inside and outside the Trust. Now that the Secretary of State has made known her decisions, about Guy's and other London hospitals, what have we learned? We have learned something about our friends.

Mrs Bottomley appears to have closed her ears to all except her civil servants. Ignoring the needs of deprived people who live in South East London, she has chosen a course, of maximum disruption and cost with minimal concern for the convenience of people who require specialist care, which fails to use the best facilities on the two sites and which will seriously interfere with patient care, research and teaching in long established departments. What is the Trust Board doing about this? So far we do not know. One might ask what has the Trust Board done at all in the last two years, except issue a regular supply of optimistic statements.

What have our friends done? The Special Trustees, custodians of the endowment given by Thomas Guy himself and, in the past, devoted, careful generous and imaginative holders and distributors of funds earmarked for the welfare of Guy's Hospital—have done nothing. They can hardly be regarded as our friends any more.

Our true friends, as readers would expect, responded marvellously. Some have appeared from unexpected sources. The Evening Standard has produced a remarkable series of articles over the last two years criticising with accuracy and power the Secretary of State's policy over London's hospitals. This has been journalism of the highest quality of which the Editor of The Standard and his Health Correspondent, Jo Revill, can be justly proud. Other newspapers too, have vigorously drawn attention to the harm the Government is doing.

Predictably, it has been a very mixed group closely associated with Guy's who have been most active in its support. The Save Guy's Campaign, brilliantly chaired by our local MP Simon Hughes, has worked tirelessly to secure a future for our hospital. Guy's men and women throughout the country have been very generous in their support. We are informed that the Campaign will continue and are heartened to learn that pressure will be maintained upon those who make decisions to ensure there is a sensible distribution of services across the Trust making both hospitals viable in the future.

A letter to HRH Princess Anne

This is a letter written to HRH Princess Anne, the Chancellor of the University of London regarding the future of the Medical Schools by Dr The, a retired local General Practitioner.

I am writing to you as a graduate of London University - Guy's Hospital (1944) and know, of course, that Your Royal Highness is not involved in the day-to-day running of the University. However, I should be grateful if your office would keep me informed about the future of the medical school.

It interests me to know the reasons behind the merger of Guy's and St. Thomas's Hospital medical schools, becoming the United Medical and Dental Schools, and as a consequence the Dean being withdrawn from Guy's. Was this the beginning of the scaling down of services at Guy's? Were the relevant people informed. Why was it decided to reduce the number of medical students at London University? Medical students need patients for their training. Without patients, students cannot learn. Fewer students need fewer facilities.

In view of current publicity about the cutting back of services at Guy's I am sure Guy's graduates would be interested to be kept informed about background events leading up to the present situation.

Since 1725, when Guy's hospital was opened, the local people have provided the material for student training. Although the population went down, it has recently increased with over 10,000 new residents following the infill of Surrey docks at Rotherhithe and other dockland areas.

Although withdrawal of funds for the hospital comes form the Department of Health, I would like to know if the closure of Guy's hospital was envisaged by the University Faculty of Medicine, at the time of the student medical and dental schools merger?

Dr IT The

University of London Response

Response from the Vice-Chancellor Professor Andrew Rutherford CBE.

The Chancellor of the University, HRH The Princess Anne, has received your letter of 31 March about the United Medical and Dental Schools of Guy's and Thomas's Hospitals (UMDS) and has asked me to reply to you on her behalf.

As you may know UMDS came into being in August 1982 following the University's approval of the desire of the two Schools to form a union. The new institution was then enlarged by the amalgamation of the Royal Dental Hospital of London School of Dental Surgery and Guy's Dental School in 1983 and the addition of the Institute of Dermatology in 1985. The rationale for bringing the work of these institutions together was to combine and thereby

enhance the great strengths in teaching and research which each of them possessed individually. UMDS is now one of the largest and most prestigious medical schools in the Country with high demand for undergraduate places and a powerful research record. These existing strengths will be further enhanced with the forthcoming union between UMDS and King's College London which will provide even greater opportunities for effective collaboration across all aspects of the biomedical sciences.

UMDS and King's College are currently developing their undergraduate curriculum in the light of recommendations from the General Medical Council published under the title Tomorrow's Doctors. As part of this initiative it is recognised that teaching should increasingly follow patients into the community both in district general hospitals and in general practices. The traditional dependence on clinical teaching at the bedside in main university hospitals is still very important but it is becoming less fundamental to the undergraduate educational process. These academic changes are desirable irrespective of decisions made by the NHS about the disposition of hospitals for service purposes.

Although Sir Bernard Tomlinson in his report published in October 1992 recommended that there should be an overall reduction in the intake of preclinical medical students to the London Schools, this was strongly resisted by the University and the recommendation was not pursued. London and the South East of England is a relatively very densely populated area, and the excellent supply of patients for the training of present numbers of medical students is not matched in any other region of the United Kingdom.

I am copying your letter and my reply to the Principal of UMDS who may be able to find a means of keeping you informed about relevant developments in South East London.

Andrew Rutherford
Vice Chancellor

Treasure Trove

Dear Sir,

Some eight years ago a collection of autographed letters was discovered in a locked cupboard in Torquay Museum. Among the 1500 examples was one from C L Dodgson (Lewis Carroll) to a friend who had asked his advice about 'visiting the sick in hospitals'. The name of the correspondent is unknown as is the date of the letter, but soon after the Crimean war seems likely. Your readers may be amused to read the following extract from it:

'...could find you work where helpers are 'like angels' visits etc'.

Let me mention two things I know about lady-visitors, useful to know. One is, I am told they are rather dreaded in some hospitals, as being so very inquisitive: they cannot rest without knowing every detail of the disease or accident, in each case: and even the poorest, I should think are sensitive about having their own personal history made the subject of a cross-examination. Another is that a lady, a cousin of mine, who wanted some such work, and whom I took to call on the treasurer of Guy's, asked him to give her an idea what sort of work would be expected of her in a men's ward - 'Reading the Bible to them, for instance?' she suggested. 'Well, no,' he said, 'we've rather too many ladies already, who do nothing but read the Bible and devotional books - and too much of that is very depressing to patients. We want ladies who will cheer them up and brighten their lives a bit - who will read them the newspaper, or get them to talk about themselves or their families' (he probably meant, more as a sympathetic listener than as a questioner).

Another friend of mine, great at visiting sick soldiers, generally went armed with a photograph album he had full of foreign views, etc etc which he said made a splendid basis for conversation.

Now I think I have written about all I should have said if we had talked about it.

I'm so glad we have met - one seems to know a friend so much better so.

Most sincerely yours,

C L Dodgson.'

Incidentally the collection also contains the last letter that Keats wrote to Fanny Brawne before he left for Italy where, of course, he died. Ironically this letter shows great concern about her health.

I am grateful to Mr Donald Goodall from drawing my attention to these letters.

Yours faithfully,

Toby Thorne

Smoking Statistics

Dear Sir,

We wholeheartedly agree with Denis Cobell's statement in Nursing Notes (Gazette April 1995) that 'health promotion is important for the future of the economy' and agree that some of the statistics shown are 'interesting'. In particular the fact that 'of people aged 25-34, 50% of the smokers are women while only 40% are men'. We did just wonder, however, what gender the other 10% are. We had a quick peek in the Medical School smoking common room but due to the dense fog could not ascertain the sex of any of the occupants. The thought did not occur that as users of this common room might make 4 or 5 visits per day of 10 or 15 minutes duration and are paid for this time wasted, should we non-smokers be paid for an extra 4 or 5 hours per week? 115% of the non-smokers in our department think that this is a good idea. 120% of our only smoker pointed out that we non-smokers are likely to live longer and thus draw more benefits from our national pension scheme. His suggestion is that non-smokers should therefore pay a higher rate of contribution. We agreed to call it quits and while he went for a fag we went back to our paper clip count.

Yours faithfully,

Medical School Salaries

Salivary Gland Lithotripter

The Salivary Gland Centre at Guy's has just obtained the UK's first salivary gland lithotripter, funded by Guy's Special Trustees.

Around 700 Londoners aged between 30 and 50 are operated upon each year to remove stones from the salivary glands.

The stones, which cause discomfort and facial swelling when eating, are removed to avoid infection although surgery carries the risk of nerve damage, resulting in facial weakness.

The Salivary Gland Centre at Guy's, means that over 70% of cases can now be treated successfully without surgery.

'This new treatment will potentially eliminate the need for in-patient treatment,' says Consultant Oral and Maxillofacial Surgeon Professor Mark McGurk.

The new lithotripter works by transmitting ultrasound shock waves through the skin to the affected area, fracturing the stone and allowing it to leave the gland naturally.

Midsummer Festival 1995

Guy's Chapel is one of the hidden gems of London. A 'gem' because, now refurbished, it is light and bright, with all its attractive Georgian features accentuated by the new colour scheme. It is a gem because its acoustics are excellent and both words and music can be easily enjoyed by both participants and audience. And thirdly, it is a gem because it contains an excellent piano which the many people who have used it admire and enjoy playing.

The last two reasons, particularly, have provided the impetus for holding concerts in the chapel, intermittently, over a number of years. However, each one has essentially been a 'one-off' and we have never managed to put together a series of concerts in the chapel. Until now.

During the last week in June, 26th - 30th, Guy's Chapel will be the venue for a Midsummer Festival with events arranged for both mid-day and evenings. Most of these will be musical and most will be held in the chapel, but please see the programme for exact details.

Apart from enjoying the events for their own sake, I think it is important that they should be in aid of some good cause to give them added incentive and purpose. Also, it seems appropriate that we should look beyond the confines of the hospital to people whose lives are less fortunate than our own.

In Zimbabwe, for instance, the winter rains have failed. There will be none now before October at the earliest. The possibility of drought is becoming a reality, with all its dire consequences. The need for water, and to find water, is urgent. Our aim, therefore, is to provide enough money for Help Age Zimbabwe to sink a borehole in a district on the outskirts of Harare where they look after many elderly people. Our aim is £750 and I am confident we can raise that amount during the week.

I am grateful to the Special Trustees of Guy's for making available a grant of £1,000 to cover the necessary expenses for the week.

Above all, I hope you will come and enjoy at least some of the week's events.

I look forward to seeing you there.

Neville Smith
Chaplain

Programme of Events

Monday 26th June
*12.30 THE FLUTEHOUSE TRIO
5.30 PM SONGS OF PRAISE
Led by:
CANON ROGER ROYLE
Retiring Collection.
Refreshments after the service.
Tuesday 27th June
*12.30 THE SOLAREK PIANO TRIO
7.00 pm THE CITY CHAMBER CHOIR
Director: Stephen Jones
Organist: Rupert Perkins
Admission by programme at the door £5.00 (including refreshments)
Wednesday 28th June
*12.30 THE RILEY-RUBINSTEIN PIANO DUO
7.00 pm SAMARITAN OR SCROOGE?
THE 18TH CENTURY IMAGE OF THOMAS GUY:
Dr David Solkin, Assistant Director, Courtauld Institute of Art.
[In aid of the Evelina Children's Hospital Appeal]
Venue: Tower Lecture Theatre
Admission £5.00 at the door including refreshments.
Thursday 29th June
*12.30 THE SOUTHWARK CATHEDRAL THURSDAY SINGERS
Conductor: Peter Wright, Director of Music, Southwark Cathedral.
7.30 pm POETRY READING:
Pat Perry, Alex Smith,
John Steer, Ray Stebbing, Elizabeth Waugh.
Admission £5.00 at the door including refreshments
Friday 30th June
*12.30 RECITAL:
Harry Twyford - Piano
5.30 pm RED RIDING HOOD:
The video of January's Hospital Pantomime
Venue: Burfoot Court Room

* Retiring collection at all the mid-day recitals.

Then and Now in Psychiatry

'Community Care'

This is the second article in a series dealing with topical themes in psychiatry from a historical standpoint. Psychosexual matters were the subject of a previous article; this second topic in the series is 'Community Care'.

The term 'community care' first appeared in the modern British literature in 1957 in the title of the Presidential address to the British Medico-Psychological Association (forerunner of the Royal College of Psychiatrists), by TP Rees, Superintendent of Warlingham Park Hospital in Croydon. Rees's title was, 'Back to Moral Treatment and Community Care'.

'Moral treatment' was the regime established by the Quakers in The Retreat, the mental hospital they built in York in the first years of the nineteenth century, aiming to provide a more therapeutic environment than they had experienced when one of their number had been resident in the York County Asylum. Moral therapy emphasised the potentially restorative properties of respectful, friendly, involved, and concerned attitudes to patients of staff who must have the right qualities of personality and be employed in sufficient numbers to be able to give time to the vital relationships with individual patients. It was the therapeutic potential of staff-patient relationships to which Rees referred. He advocated the development of nurse-patient relationships while patients were in hospital, so that nurses could follow patients from hospital into the community.

'The term 'community care' first appeared in the modern British literature in 1957...'

During the 1960s and 1970s there were two contrasting strands of enthusiastic service development. On the one hand, keen asylum superintendents and their staff developed a wide range of different worlds whose environments were geared to patients with different needs. At the same time, others suggested that psychiatric units in district general hospitals should be developed and could deal with all the psychiatric admissions for defined catchment areas. In the event, the general hospital movement won the day and a government circular in 1974 proposed the establishment of a DGH-based service in every district. The acute catchment unit at the former St Olave's Hospital in Bermondsey was one of the pioneer DGH units; the Unit consultants, Arthur Oldham and Raghu Gaind, published influential reports about the drug treatment necessary to treat the most acute patients in such settings; systemic haloperidol was a favoured method.

For the politicians and planners it followed from the DGH policy that the large asylums could be reduced in size and closed (with attractive advantages, it seemed, for the Treasury). This policy has been implemented with increasing speed since the mid-1980s, fuelled by a melancholy series of inquiries into problems at a series of poor psychiatric hospitals; the 1970s enthusiasm about the positive potential of good hospitals appeared to be soon forgotten. Initially, the main thrust of policy was the relocation of the long-stay patients for whom hospital had become home. The levels of disability of individual patients would be assessed in the hospital where the staff know them well, to inform plans for relocation to more or less supported accommodation, the required range of which may be from ordinary housing at one extreme to a continuously staffed community home on the other.

'... the large asylums could be reduced in size and closed (with attractive advantages, it seemed, for the Treasury).'

The relocation of long-stay residents in such accommodation has usually been extremely successful, and the revival and progress of individuals towards more normal existence can be a modern enthusiasm. Recently, however, the success of much resettlement work has tended to be overshadowed by another facet of psychiatric activity, concerning the acutely severely mentally ill, who for the most part are a different group of individuals since the relapse and

re-admission rates of chronic resettled patients tend to be quite low. In London (and other cities) particularly, the closure of acute psychiatric beds which has accompanied the run-down of the large hospitals has, in the opinion of most involved clinicians, gone too far and there is a continuing mismatch between acute bed demand and availability. One of the most clearly established sets of research findings in this field is that individuals suffering from schizophrenia are very sensitive to social stimulation in their environment. Clinical state tends to be worse in circumstances of either over- or under-stimulation. Conditions of pressure to do things, move on, interact with people whether one feels like it or not, tend to be greater in acute hospitals and in the non-hospital city environment than in rural (including large hospital) settings. This may well contribute to the present frequency of behavioural disturbances associated with acute schizophrenia in urban communities. There are plans to increase the numbers of sub-acute beds, allowing less frenetic progress through today's acute psychiatric wards.

It can be difficult to realise the extent of the differences in patterns of psychiatric service provision now and twenty years ago. In SE London, the 1970s were distinguished by enthusiastic general hospital psychiatrists at Guy's and at St Thomas'. At St Thomas' the influence of William Sargant and John Pollitt was immense, and both are well known for their involvement in physical treatment methods. At Guy's the York Clinic was widely known for the work of David Stafford-Clark and John Fleminger. In those days, neither hospital had a mandatory commitment to deal with patients from any defined 'catchment area'. St Olave's hospital did, and provided the hospital catchment service together with Cane Hill hospital (Coulsdon, now closed) and Bexley hospital (closing). In the early 1980s, when the St Olave's unit closed, Guy's offered catchment facilities. Meanwhile, for Lambeth residents the main hospital provision was at Tooting Bec and the South Western hospitals. Tooting Bec has closed in 1995, and a new unit will shortly open at the South Western.

The enormous strides which have been made in recent years towards more humane service provision for the severely mentally ill in SE London must not be overlooked in the light of day-to-day preoccupations with bed provision for the acutely mentally ill who need longer hospital stays than current facilities make possible.

JP Watson

Sherlock Holmes and the World of Medical Literature: 1966 to Date

Part 1: 1966-1980

As a long-term fan of Sherlock Holmes, it was natural that during my training at Guy's I should develop an interest in the medical side of the Canon. Indeed, I spent many happy hours reading late 19th century volumes of the British Medical Journal and Lancet! The impact of Holmes on contemporary medical literature also interested me, and in fact prompted me to become a member of The Sherlock Holmes Society of London. After seeing the welcome re-publication of Maurice Campbell's excellent series of Holmesian articles in the Gazette (last seen in 1980), I thought it might be interesting to Gazette readers to commit some of my findings to paper.

Background to the present article

The Sherlock Holmes stories are inextricably linked with medicine, largely as a result of the medical training and experiences of Dr John H Watson and his literary agent, Sir Arthur Conan Doyle. It is also well-known that Doyle was greatly influenced by Dr Joseph Bell, one of his teachers at medical school, whom he said 'had an eerie trick of spotting details. If he were a detective, he would surely reduce this fascinating, but unorganised business into something nearer to an exact science' (Doyle, 1924). Another link is that Holmes may have been named after a Dr Oliver Wendell Holmes of Boston (Dirckx, 1979). Little wonder then, that Holmes remains a subject of much interest and relevance to the medical profession. Indeed, within the 60 Holmes stories are references to 68 diseases, 32 medical terms, 38 doctors, 22 drugs, 12 medical specialities, 6 hospitals, 3 medical journals and 2 medical schools (Westmoreland and Key, 1991).

Interestingly, Doyle himself did not appear to believe that Holmesian methods were as suitable for medicine as they are for detection, and in an address in 1910 to students at St Mary's Hospital in London on 'The Romance of Medicine', he warned against undue materialism and intellectual priggishness, and said that he had 'known men in the profession who were stuffed with accurate knowledge, and yet were so cold in their bearing, and so unsympathetic in their attitude ... that they left their half-frozen patients all the worse for their contact' (Doyle, 1910). He emphasised 'the value of kindliness and humanity as well as of knowledge'. This view is supported by the following quotation from The Times (22nd April 1981): 'The hospital, with its specialised equipment, focuses on disease [and] often leads to depersonalisation, of doctor and patient alike. The doctor becomes a medical Sherlock Holmes. In the process the patient may feel that he has ceased to be a person and has become a case'. The reader must decide which approach to medicine is the most desirable, although I hope it would be both!

Materials and methods

The literature search was conducted using the Medline CD-ROM database into all articles written about or containing references to Sherlock Holmes in the world medical literature from 1966 to date (1966 was the earliest Compact Disc available). This database covers medical journals, but not the many excellent books written on medical aspects of the Canon and its creator (Rodin and Key, 1992; Smithers, 1990; Accardo, 1987; Shepherd, 1985; Rodin and Key, 1984; Simpson, 1983; Gerber, 1983; Liebow, 1982; Key, 1981; Van Liere, 1959).

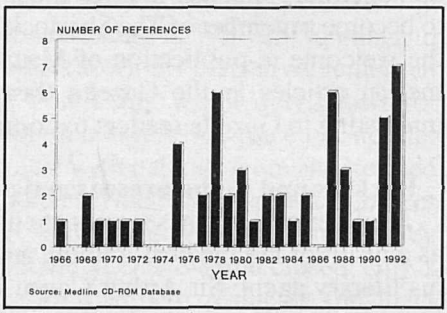

Figure1. Annual number of references made to Sherlock Holmes in the world medical literature 1966-1992.

Literature search results and discussion

General Findings

There was a significant increasing trend in the number of medical references made to Sherlock Holmes between 1966 and 1992 (Figure 1; $P<0.005$),

indicating a continuing healthy interest in the Canon, perhaps accentuated by the recent 1987 centenary of 'A Study in Scarlet' - the first Holmes story. In the following text, references are considered in chronological order, excluding those in which only a fleeting mention of Holmes was made; usually as a symbol of careful observation and deduction (Beck, 1992; Horn, 1991; Epstein et al., 1991; Van Wallendael and Hastie, 1990; Daschner, 1988; Zapata, 1987; Serup, 1987; Kanterman, 1983; Portioli and Valcavi, 1981; Nance, 1980; Ackerman, 1978; Petrone, 1978; Elfenbaum, 1971; Anonymous, 1970). In addition, relevant items not included in Medline from other (principally Sherlockian) sources are discussed.

1966

In April 1966, David Musto of Yale University published a paper in the Journal of the American Medical Association (JAMA) on Sherlock Holmes and heredity, citing examples of Holmes's close observation of family traits such as his deduction from family portraits in 'Hound of the Baskervilles' that Stapleton was a Baskerville. He noted how Holmes's mentor, Joseph Bell, contributed an article in 1900 to the Scottish Medical and Surgical Journal on heredity in disease, and how Holmes himself wrote a monograph 'On the Variability of Human Ears' for the Anthropological Journal in 1888, a subject which served him so well in 'The Cardboard Box'. Unfortunately, the British Library does not appear to stock the latter journal....

Many of Holmes's inferences regarding heredity might be viewed as incorrect today, such as his belief in 'reversion' to explain wickedness ('Hound of the Baskervilles'), the inheritance of general personality traits ('Speckled Band', 'Copper Beeches'), and his deduction of the character of families from the behaviour of their pets ('Creeping Man')! Nevertheless, these views were consistent with prevailing concepts at the time, and did not interfere with the solution of problems. Finally, Musto considered Holmes's own ancestry, suggesting that he may have been so cognizant of hereditary features because of the remarkable inherited traits in his own family, such as the superior intelligence and powers of observation and deduction shared with his brother Mycroft. Thankfully for us, however, Sherlock did not share his brother's laziness and Diogenical interests!

1968

A further article by Musto in JAMA considered the relationship between cocaine, Sherlock Holmes and Sigmund Freud (Figure 2). Musto pointed out how Holmes's own use of cocaine would have evoked no suspicion in contemporary society. Indeed, even the 78-year-old President of the British Medical Association, Sir Robert Christison, reported how chewing coca leaves enabled him to walk 15 miles and accomplish other arduous tasks without exhaustion, and cocaine was an ingredient of Coca-Cola until 1903! Musto proposed that Holmes suffered from occasional melancholia, not unusual in a man of creativity, which he self-treated with cocaine. There is no doubt that Holmes's cocaine use ultimately became a problem, however, which Holmes later referred to in 'Missing Three-Quarter' as an 'instrument of evil'. Musto proposed that this problem reached a critical stage in 'The Final Problem', when Holmes exhibited signs of chronic cocaine use, such as a suspicious frame of mind, leading him to weave elaborate schemes to explain facts of whose significance only he was aware. One could easily question the claim that Moriarty was a figment of a deranged imagination, however. Nevertheless, Watson may have turned to the medical journals for help with Holmes, as indicated by the following (true!) quotation from the Lancet:

Figure2. An historic consultation? Sherlock Holmes and Sigmund Freud (taken from Musto, 1968).

'COCAINE CRAVING.
To the Editors of THE LANCET.

Sirs,- I have a patient who suffers from cocaine craving. I find it impossible to keep cocaine out of his reach. This habit has brought him into a very low state of health. Perhaps some of your readers might be able to give me some suggestions as to treatment. I have tried the usual remedies in vain. He suffers from great nervousness, sleeplessness, and has become very thin.- I am, Sirs, yours truly,

Oct 28th, 1890. IRENE.'

The pseudonym Irene would of course fool no Sherlockian (Irene Adler - otherwise known by Holmes as 'The Woman'). So did Holmes need treatment? Following Reichenbach Falls, between 1891 and 1894, Musto proposed that Holmes may have turned to Sigmund Freud, the Viennese neurologist, for help. This is a popular view, which has even been the subject of a feature film ('The Seven Percent Solution'), but, whatever happened, cocaine use had ceased to be a problem for Holmes when he returned to London in 1894. Interestingly, a review in the Sunday Times (26th February 1984) of 'Freud and the Culture of Psychoanalysis' by Steven Marcus, commented on how 'both Sherlock Holmes and Freud relied upon the overlooked, significant detail. What others dismissed as trivial often proved to be the key to unravelling the puzzle.' It is possible, therefore, that Holmes repaid Freud for his psychiatric attentions in kind!

In a further article in JAMA on 'Murder in Medical Education', Anderson discussed the relevance of detective fiction to medicine, and in particular how to use Sherlock Holmes as a model for medical education. The only other reference to Holmes in 1968 was a report on the Sherlock Holmes Society's trip to Switzerland, comprising a learned Queen's Counsel as Moriarty, senior civil servant as Sherlock Holmes, and Guy's own Dr Maurice Campbell as a boisterous Dr Watson (Lister, 1968).

1969

In a letter to JAMA, Nusynowitz recounted the case of a drug company representative noted to have acromegaly. The man had suffered from the condition for about 5 years, during which time he saw about 10,000 physicians in the course of his job, none of whom spotted his problem. Dr Nusynowitz thus concluded how, despite the sophistication of modern medical equipment, the eyeball, properly used, remains an excellent - and the most important - diagnostic tool!

1972

In the Spring of 1972, Craig published a paper on ophthalmological aspects of the Canon, but this unfortunately was unobtainable.

1974

Of interest to medical Sherlockians may be an article by Surgeon Captain H Curjel published in the Autumn 1974 issue of The Sherlock Holmes Journal (SHJ), entitled 'A Day in the Life of Young Stamford', the doctor who introduced Watson to Holmes for the first time in 'A Study in Scarlet'. Curjel made a further medical contribution to the SHJ in a letter dated August 1979 concerning Dr James Mortimer, and how he could be a general practitioner with the single Conjoint Diploma of MRCS (Member of the Royal College of Surgeons). The answer was that by 1870 the MRCS was a comprehensive examination in Surgery, Medicine and Midwifery, whereas the Conjoint Diploma was only established in 1886. Curjel further discussed why Mortimer declined Holmes's courtesy address of 'Doctor', possibly because Mortimer's hopes of a consulting practice had been dashed by his marriage, such that his phrase 'Mister, Sir ... a humble MRCS' really meant 'alas ... not an FRCS'.

1975

During 1975 a series of letters appeared in the Canadian Medical Association Journal concerning the link between Sherlock Holmes and Marfan's syndrome. Cooperman proposed that Jefferson Hope in 'A Study in Scarlet' exhibited signs of Marfan's syndrome, and, assuming this to be the case, that Doyle had predated Marfan's classic description of the syndrome in 1896! Redmond, the Chief Librarian at Queen's University in Kingston, Ontario, wrote to add that this story had in fact been published in late 1887, and written not later than 1886, thus making Doyle's description more than a decade older than Marfan's, and all the more remarkable as Doyle had then only just left medical school. Bates contested Cooperman's diagnosis, proposing syphilis as an alternative, but, in reply, Cooperman pointed out that syphilitic heart and blood vessel disease have no specific predilection for tall people like Jefferson Hope, and that Hope was rather young to have died of a syphilitic aneurysm. From the available evidence, Cooperman's diagnosis of 'Doyle's syndrome' would seem the most plausible!

1977

In 1977, an article by Smith and Beerman in the International Journal of Dermatology discussed the links between Sherlock Holmes and dermatology, pointing out how skin specialists above all others follow closely the teachings

and methods of Holmes. Interestingly, this is a claim that has been made by a number of medical specialities. Nevertheless, there is no doubt that the Canon contains many references to skin problems, and Holmes is known to have carried out basic research into post-mortem bruising ('A Study in Scarlet'), and written monographs on the various dyes and techniques of tattooing, and effects of trades on the form of the hands. The latter monograph may well have been the model for Ronchese's book 'Occupational Marks', published in 1948. The two key dermatologically-related stories in the Canon, 'Blanched Soldier' and 'Lion's Mane', which curiously were the only two stories to be related by Holmes himself, are considered in the 1983 section later.

In an editorial in JAMA, Vaisrub drew parallels between medicine and detection, and recalled Snow's classification of detective stories as either 'classical' or 'romantic' (Snow, 1977). In classical stories, such as those written by Doyle and Edgar Allan Poe, the detective solves his cases by deductions based on observation and logic, much like the scientist, whereas in the romantic type of story, epitomised by Dashiell Hammett, the detective is unpredictable, intuitive, and emotional. Vaisrub commented that although these two extreme types of medical diagnostician undoubtedly exist, such metaphors are oversimplified, and there is for instance a third type of medic, the technological diagnostician, who is more at home with computers, scanners, and fibre optic instruments than with the history and physical examination. Nevertheless, useful parallels can be drawn between medicine and detection, as shall be seen later.

1978

In 1978, an interesting series of papers on Holmes appeared in the journal Transactions and Studies of the College of Physicians of Philadelphia, although this source is sadly not readily available. One of these articles, by Aronson, discussed aspects of forensic pathology in the Canon; the interested reader is recommended to look up as a substitute Jenny Ward's excellent paper 'Sherlock Holmes and Forensic Investigation', published in the Winter 1991 issue of the SHJ, which considered the extent of Holmes's knowledge in such areas as tobacco and the typewriter, and how it compared with contemporary forensic science. Ward concluded that, whilst the popularity of Holmes and Watson has led to a present-day public perception that they were the only

scientific detectives of the period, they were in fact only two of an elite band of consulting forensic experts.

On a related theme, The Times newspaper in July 1986 carried a piece on an article in the Journal of the Forensic Science Society which bestowed upon Holmes the accolade of being the father of modern forensic science (SHJ Editorial Notes, Winter 1986). Those in favour of this view included an Indian expert citing Holmes's work with plaster of paris, and a Frenchman who wrote in the mid-1920s that Holmes had inspired his own innovation in the theory of interchange- the reciprocal transfer of material through contact; for example, an attacker stabs someone and then leaves blood on a door-knob. Against this view of Holmes was a former director of the Metropolitan Police Forensic Laboratory, Dr Henry Walls, who told The Times that the science in the Canon was 'ridiculous', and that Holmes's ideas about typewriters having as much individuality as a man's handwriting have no basis in fact. Dr Walls's successor, RL Williams, refuted these comments in a subsequent letter to The Times dated 18th July, however, giving examples of good scientific practice in the Canon. He concluded that Dr Walls's comments concerning typewriters must have been 'mis-reported', as much valuable work on typewriter comparison had been done while Walls was Director!

In another article in Transactions, which I was able to obtain, Miller discussed the habit of Sherlock Holmes, and was amongst the few writers to have suggested that Holmes did not use cocaine at all! Rather, Miller proposed that Holmes deliberately deceived Watson in this regard, and instead of cocaine used a belladonna alkaloid. There are a number of flaws in this argument, however. For instance, Miller's references were dated, and propagated long-dead myths about the cocaine user being criminally inspired, unreliable, unable to perform ordinary duties of life, morally debased, psychotic, and/or neurotic. Because Holmes was none of these, Miller concluded that he must not have used cocaine. As shall be seen later (1988 section), these characteristics are far from inevitable. Another outdated claim made was that 'no one uses cocaine occasionally'. Finally, Miller noted how the British Pharmacopoeia of 1885 did not list cocaine as suitable for injection; nevertheless, Freud is known to have injected it at this time, and Holmes was equally capable in the field of experimental pharmacology.

Other articles in Transactions were by Foster on Holmes and United States place names (of uncertain medical relevance!), and Beerman on Holmes and medical history. If any American readers have access to these references, I would be indebted if they could forward copies to me.

1979

The final publication concerning Holmes in Transactions was a letter by Grilly regarding Miller's article, probably covering similar ground to his 1980 article in the SHJ (see 1988 section). The only other article of significance about Holmes in 1979 was by Dirckx on Sherlock's relevance to the art of dermatologic diagnosis (see also 1977 and 1983 sections), such as his thoroughness, perception, discretion in obtaining a history, and his comment in 'A Study in Scarlet' that the technique of investigation is one which can only be acquired by long and patient study: 'Nor is life long enough to allow any mortal to attain the highest possible perfection in it'. This echoes the aphorism of Hippocrates that: 'Life is so short, and the art takes so long to learn'. Nevertheless, the medic would disagree with Holmes's comment in 'The Hound of the Baskervilles' that: 'There is nothing more stimulating than a case where everything goes against you'!

1980

In 1980, Massey wrote a monograph on links between Dr Joseph Bell and Holmes (as mentioned earlier), and Brenner discussed the relationship between Holmes, Watson and neurology (see 1985, 1987 and 1991 sections). In addition, a series of ten articles by the late Dr Maurice Campbell were published in the Guy's Hospital Gazette between April 26th 1980 and September 26th 1981. Though not included in the Medline database, this reference deserves mention as it is one of the most thorough and interesting discussions made of the medical content of the Canon, with an emphasis on teaching, and is thoroughly recommended.

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John S Gilbody

The 407 Art Club Exhibition

March 27-31 1995

The quality of these exhibitions improves with time. The originators of the 407 Art Club are still exhibiting 20 years after its inception and they too have been producing more assured work compared with their early contributors. The continuation and success of the shows owe everything to Terry Gibson and Matteo Adinolfi who have found time in busy work schedules to cajole and encourage their fellow artists.

The name '407 Art Club' derives from an objection raised by the Medical School many years ago. The students at that time were not necessarily more cultured but they possessed ownership of the title, 'Guy's Art Society'. Members of School and Hospital staff wishing to mount an exhibition were pleased to comply by substituting the local telephone exchange number '407' in their title, forgoing the name Guy's in deference to undergraduates. Ironically, very few student exhibitions have been mounted in the last two decades and although they sometimes exhibit with the 407 Club, none did so recently despite widespread advertising.

The artists on display were largely familiar to those who know Guy's well. However, there were several new contributors and the first picture to greet visitors was a bright pastel painting, 'African Women'. This was a bold debut by Ursuline Loubser, capturing the uninhibited colours of her home country.

The next pictures were by contrast examples of work in the most English of media, watercolour. Margaret Dinkeldein has a professional skill. Her studies of apple blossom, views of Central Park, New York and of the Isle of Wight were finely executed in classical fashion. These were amongst the best pictures she has shown at the 407 Art Club.

Although Matteo Adinolfi has retired from the staff at the School he has actually moved his laboratory work to another institution. Presumably he still

finds some time for leisure because he was the most prolific artist on display. His penchant for abstract work and collage in particular, his deep knowledge of modern artists and his attractive philosophy on life and work combine to make his pictures a focus of discussion. Imaginative use of old tickets, wood, paper and thread characterised ten separate pictures, some linked thematically or stylistically. They stood out as serious works.

'Portait' by SusannaNasskau

Susanna Nasskau is a professional illustrator employed by the School. This was reflected in the quality of her pastel portrait and the watercolours of hands. Her flower study was a meticulous painting that attracted many plaudits from visitors.

Another classical watercolour scene was provided by Eileen James. This was a country cottage glimpsed between trees in winter. There was a homely feel to this picture. The artist is obviously deeply committed to painting and the Club looks forward to displaying her work again.

The small oil paintings by Gordon Rolfe were that of thatched cottages and a castle in Scotland. These were neatly executed and brightly coloured. He, too, is a newcomer and one hopes that he will continue to exhibit at this venue.

'Shepherd's House, Guy's' by Terry Gibson

Terry Gibson displayed three watercolours of Guy's scenes and three of Hyderabad, India. The pictures of the forecourt and the Memorial Park revealed an appreciation of how light and shadow can give depth and atmosphere to a picture. The Indian views attempted with some success to convey the feeling of heat, dust and bright light.

'Hunt's House'
by Roy Spector

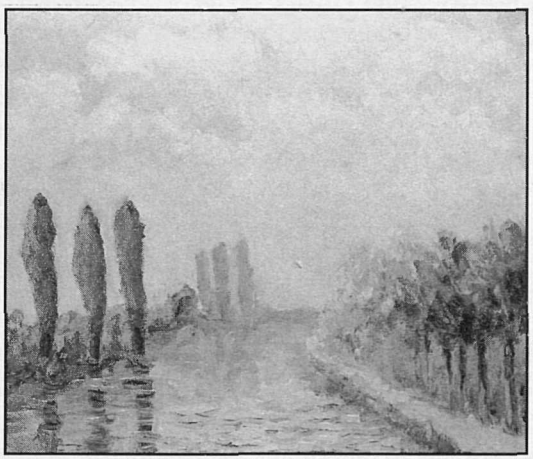
Additional watercolours of Guy's Hospital were the product of Roy Spector. The Front Gate and Hunts House were portrayed in delicate colours while remaining recognisably true to the subjects. The view of Petts Wood and the study of sweetpeas were further testimony to Roy Spector's talent with ink and watercolour.

Always popular and in retirement, a keen observer of events at Guy's, William Mann continues to exhibit his oil paintings. The Thames and Cassis were two lovely pictures, displaying great feeling for the scenes transferred to canvas. The Corot like interpretation of the river evoked summer days and picnics at the water's edge.

The etchings of Cedric Mims were both profound and whimsical. Whatever allegorical interpretation placed on them by viewers, none doubted the draughtsmanship of the artist. These stark illustrations provided a sharp counterbalance to the gaiety of the pictures mounted on either side. They were a popular element of the exhibition.

The woodcut portraits by Sidney Leibowitz were additional examples of this artist's wide talents. They were unlike any other work on display and their quality enhanced the series of pictures mounted around the perimeter of the Studio.

In the centre of the room were thirteen low fired pots by Jane Gibson and three papier mache goats by Vicky Mims. The former has established a reputation as a Kent potter who



'The Thames' by William Mann

has refined traditional techniques from the Gulf and S. Asia to produce a distinctive style of pots fired by paper, wood or sawdust. The three 'Contented Goats' were a revelation of what can be achieved with papier mache. The animals were constructed with such skill that each was endowed with character. They provided a deserved central focus for what was an outstanding exhibition.

It was noteworthy that of the thirteen artists on display, five were retired members of the consultant staff. The continued success of the exhibitions depends on recruitment of new artists. Retirement is not a pre-requisite. Any students or employees of School and Hospital wishing to display work at future exhibitions should contact Dr T Gibson on extension 4310.

Our Art Correspondent

Guy's during the War

1939-1945

The following is a reprint of letter submitted to the Ousel, the Journal of Bedford School from John V Kilby, a Guy's Graduate.

A Bedfordian in Belsen

Guy's Hospital, London Bridge, SE1.
16th June 1945.

Dear Sir

I feel I should write and tell you something of the work of the Medical Student Relief Unit in Belsen Concentration Camp, and of some of the aspects which show up the enormity of the horrors of Belsen.

We arrived at Belsen after the British had been in occupation for eighteen days, and so did not get an idea of the place as first found. The 10,000 corpses in the enclosures had already been removed by the SS guards under British persuasion - they worked for about a twelve-hour day or more at the double and with no respite - and water and electricity were again laid on. All this organisation was carried out by a comparative handful of RAMC and Artillery personnel, with Hungarian labour.

The camp was composed of two separate compounds for men and women, each compound being divided into wired-off laagers of five or six huts. The huts were intended to hold thirty people originally, but we found them with anything from two hundred to five hundred, and were told that they had held more.

Our job was to keep the internees alive in the huts until the hospital accommodation could be made to them in the SS Barracks and Panzer Training School adjoining the camp, where we could treat them fully. The filth of the huts was indescribable, for in the fortnight preceding the liberation the SS, in an effort to control the typhus epidemic, had forbidden everybody to leave the huts, although every inmate had diarrhoea and most vomited all food. The

newly dead in the huts were not all cleared away, and we found the bodies being used as pillows, tables and coverings by their living comrades. The Wehrmacht P's O. W. *(sic)* were put on a job of a daily round of collecting and burying the dead, when the SS had finished the mass clearing. The death rate when we started was about five hundred daily, but fell to fifty after a week.

Feeding was the next problem, as when people have been grossly starved for a long period their digestive systems undergo changes making it impossible for them to take normal food. As there has only been one comparable famine observed, that in Burma recently, little was known about the best form of food to use en masse. After trial and error it was found that the food that most could retain was the gruel used in the Bengal famine - a mixture of flour, milk powder and sugar. This, together with various stews, was the food used until, on hospitalisation, adequate protein therapy could be carried out. The food was cooked in thousand litre boilers by fit internees in the five camp cookhouses.

The two outstanding diseases were typhus and tuberculosis. The former took a terrible toll before it was brought under control by effective anti-louse treatment with A.L. 63 Mk. III, a new louse powder. Even if people recovered from the disease, the complications, together with their general weaknesses, often proved fatal.

Tuberculosis was clinically obvious in about 30 per cent of the sick, while there must have been an overall rate of 50 to 60 per cent. in the whole population. There were many surgical conditions, notably abscesses and gangrenous bed sores which often had eaten through to the underlying bone.

The apathy of the people was appalling, the sick not caring whether they lived or died, and the fit - those who could walk and collect their own food - just sitting about, not bothering to help themselves or anybody else. One woman whom I was trying to persuade to drink the foul-tasting casein hydrolysate by telling her that it was the only means of keeping her alive, said 'What reason have I to live? My family are all dead, my home is no more, and I shall never be really strong. I may as well die.' This was the attitude of many of the starvation cases.

We saw few results of the tortures inflicted by the SS and their Medical Officers, as they mostly proved fatal; but many stories I heard of Intravenous benzine injections -said to be experiments concerning arteriosclerosis - and of subcutaneous injections of boiling candle wax. Teeth with gold fillings were wrenched out with no anaesthesia, and floggings, of course, were daily

occurrences. Despite all this, I think that the greatest torture of all was the gross privation and neglect suffered by all indiscriminately.

Gradually the camp was evacuated, and the inmates taken to hospitals in the SS area, via the human laundry. This was a large panzer stable with about fifty tables on which the people were scrubbed by German nurses and covered in A.L.63. About 800 were dealt with per day, regardless of their condition. We then treated them in the hospitals giving casein hydrolysate where necessary, and to the rest proper medical and surgical attention under RAMC supervision.

On May 21st the last hut was ceremonially burned, together with a picture of Hitler and a Nazi flag, and now there stand at the main gate two big painted signboards saying, in English and German:

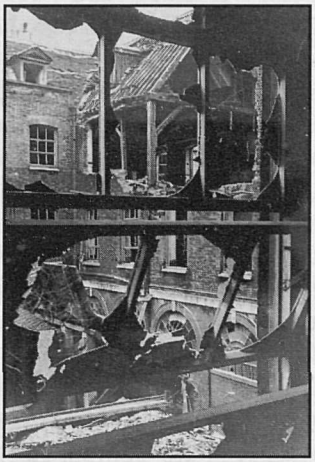
'This is the site of the Infamous Belsen Concentration Camp, liberated by the British on 15th April, 1945. 10,000 unburied dead were found here, and another 13,000 have since died, all of them victims of the German New Order in Europe, and an example of Nazi Kultur.'

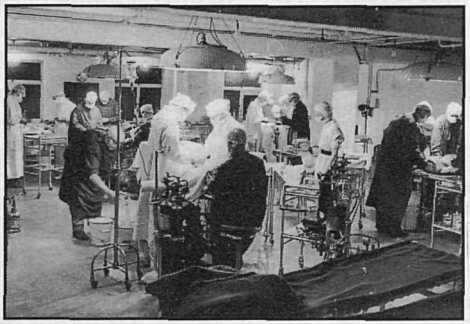
I apologise, sir, for the length of this letter, but there is so much which should be told of Belsen that I hope that you will not feel that the space is wasted.

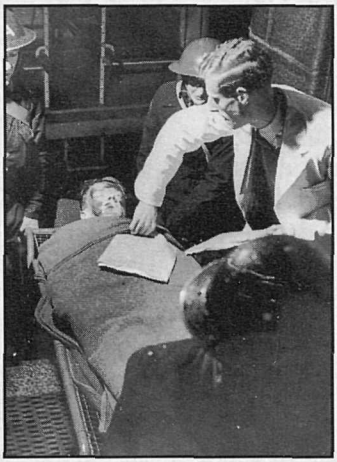
Yours faithfully

John V Kilby.

Views of Guy's during the Second World War







'Moral of the Work. In war: resolution. In defeat: defiance. In victory: magnanimity. In peace: goodwill.'

Winston Churchill ***in*** *Second World War (1948) vol 1, epigraph.*

Just looking at the pictures? Colour guides for clinical students

The 'F' word is an important part of medical studies and students are bound to spend a large amount of time loading facts in to their heads. It is estimated that a A to Z of 40000 new terms must be learnt along the course of becoming a doctor. If you are still on A for ankle or B for brain you have a fair way to go before X for xanthelasmata or Z for Zieve's syndrome. Along with this hopefully ordered collection of facts and figures it is also essential for the student to become versed in clinical skills and signs of disease. Facts are ready at hand in the textbooks and so, to some extent, are the details of clinical practice and signs of disease but often the textbook is not adequate. The best way to learn this part of medicine is on the wards but help is at hand in the form of many new colour guides.

There are different styles of these colour guides and there are a large number of titles available. The Churchill Livingstone series of **Colour Guides** covers a large range of medical specialities including recommended titles on Haematology, Gynaecology and Ophthalmology. These are pocket size books and are very convenient; the **ABC Picture Tests** are also useful colour guides with questions and answers about every picture. On the medical and surgical side of things the **Wolfe Diagnostic Picture Tests** present many signs, tests and pathological specimens with probing questions.

The new **Atlas of Clinical Diagnosis** published by Saunders (ISBN 0702018465 22.50) and written and compiled by M Afzal Mir is slightly different from other guides. It contains a head to toe, hands to eyes guide to physical signs. There are large sections on the face and the hands - always the starting point for the clinical exam - with colour photographs of both common and rare. The individual sections are arranged with large clear photographs and explanatory text. Along with the pictures there are summary tables and rather strange body diagrams summarising the signs and symptoms in individual conditions. The conditions of the eye and the ear are covered with many photographs of the retina and the tympanic membranes. The book's size allows larger photographs than some of the pocket style guides. This is important for the clarity of pictures - retinal shots especially.

Overall this guide is a well presented, useful book and aid to adventures on the wards. You may find signs never look as good in the flesh!!

Richard Littlewood

Mr or Ms?

A little while ago I read a curious article in the nursing press. It was written by a 'male nurse' who thought his gender was not a significant matter, and that it received too close attention when noted next to his profession by patients, but more particularly by other staff.

He went on to remind readers that he just wanted to be an ordinary practising clinical nurse, not interested in the higher echelons of either teaching or management. I am sure readers do not need me to remind them, though this is not the situation in the Guy's & St Thomas' trust, that in nursing men predominate in the higher posts, despite their numbers in the profession remaining at less than 10% of the total staff. I dare say readers would shout 'sexist' or 'silly', if I added some comment about cream always rising to the top.

We live in an age when political correctness consumes all before it, in principle. But underneath people and persons, there are still, strange as it may seem, men and women. Women are more than 50% of the population and live longer. But men still seem to rule.

In nursing it is hard for patients outside specific areas to think of nurses as other than female in most instances, because the nurse who cares for them is most likely to be a women. I am also aware that women are regarded, in may cases, as more caring than men. This maybe because most of us have had a 'mom' who has been our closest significant person in early childhood. When we fell down, or were dragged screaming to the dentist, it was usually mum who was there. Seldom are dads there at such critical times, although with changing employment patterns, it can be expected that this position may change in the future.

I recall the days when posts in nursing were sometimes specifically advertised if it was a 'male nurse' required: equal opportunities have long seen this distinction out of the way. Patients, as the Charter tells them, have rights. If they prefer a female nurse, then presumably they are entitled to one. My guess is that many of them will make this choice. Being a patient or client is a very sensitive matter, and although once a relationship is established between male nurse and his patient, that patient's initial prejudice may be knocked down, it is often the preference made without foreknowledge that may reign.

The male nurse referred to in my opening paragraph was more prepared to accept patient choice, but felt somewhat rattled each time a colleague asked why he - a man - wanted to take up nursing. I think he felt that the question was posed with the assumption that he was invading female territory.

Well, in view of many men rising to the top of the profession, and the enhanced reward this brings, it is hardly surprising women should adopt a defensive stance. Why should these men

rule their profession? A position little diluted by the recent antics surrounding the departure of the UKCC Registrar - a man. But for a lot of men, who just wanted to 'care' for their fellow species, and not push them about, there is the reverse logic with which the unhappy man is confronted.

Another aspect is the increasing use of technology, computers and indeed the mechanization of care. Men seem to be happier at this end of the job, their head, as it were, 'under the bonnet', sorting things out in a matter-of-fact, non-feeling and unemotional way. Is this true?

Our fellow professionals, doctors, of course find themselves in the reverse situation. Yet, I am aware that many patients, despite some initial caution, often find a women doctor a better bargain than a male. This is even the case when men patients are discussing what they regard as sensitive issues, or about their 'private part'. And I am not referring to the male patient who may gain pleasure from dropping his trousers in front of a woman.

I believe, despite the range of personality differences between individuals, that it is impossible to ignore the gender of the person you are interacting with.

However we may attempt to take a stand which avoids this, there is too much, deep in the stillness of our heredity, to ignore it altogether. Whatever environmental influences we may deploy, a man in nursing is still somewhat unusual. Simply in terms of numbers, it means that most patients will predicate the term nurse with the pronoun she. Even the recent arguments with the government about pay, boils down to nurses, being mostly women, taken as easy fray, compared with their fellow professional in medicine, most of whom are men.

It currently appears, regrettable or not, that women have to become more like a man to get their voices heard; if men want to retain the clinical and caring role they have to put up with the assumption that they are putting that part of their makeup which is labelled 'female', to the fore. Any young man joining our profession must be prepared for this prejudice, and the more he fights against it, the more he is displaying masculinity.

Denis Cobell

Elma Gertrude Casely, MBE

Physiotherapist. Born Peterborough, South Australia, October 28, 1904. Died Adelaide, March 30 1995, aged 90.

Elma Casely was a pioneer physiotherapist with vision, alert to all opportunities that could assist people to cope with their circumstances.

She was the first qualified physiotherapy teacher in Australia, and was instrumental in introducing prenatal and postnatal exercises for women in the 1930s.

Elma, third daughter of Lynthorne and Adeline Casely, and great-granddaughter of three pioneering families, lived her life in service to the community, particularly through her physiotherapy profession.

Born in 1904 in Peterborough, South Australia, she later attended the local Methodist Ladies College from 1912 until 1920, where her abilities and qualities of leadership were acknowledged as school prefect and captain of the hockey and tennis teams.

In 1923, she undertook a diploma in physiotherapy, and after qualifying she worked in private practice for four years. She was then assisted financially by a physiotherapist who realised her potential to go overseas to Guy's Hospital, London, to undertake the two-year physiotherapy teacher training course of the Chartered Society of Physiotherapy.

In the qualifying examination results she topped Guy's Hospital, and came second in Great Britain.

When she returned to South Australia there was no teaching position for her so she continued private practice and assisted with training and examination of students without payment.

She was the only qualified physiotherapy teacher in Australia, and was asked to go to Brisbane in 1940 to establish the clinical teaching program for a physiotherapy diploma in Queensland. In 1945, she was appointed lecturer and later senior lecturer-in-charge at the University of Adelaide, where she developed a physiotherapy diploma that soon became recognised abroad for its high standard.

She was always a person of vision. In 1931, she had begun the first physiotherapy treatment in Australia for patients with heart and lung disease, and in 1935 she encouraged and supported the inauguration of a maternal and infant welfare scheme, under the Jubilee Memorial Fund.

She pressed for the inclusion of instruction in pre- and post-natal exercises by physiotherapists at the newly established branches of the Mothers and Babies Health Association.

She was instrumental in starting these classes in the Unley and Norwood centres in Adelaide.

Up to this time some postnatal exercises had been given, but only in private practice. Classes were also started

at Hilton and Glenelg and by 1941 in the Queen's Home (Queen Victoria Maternity Hospital).

This work in the MBHA centres and the hospital was done for several years in a voluntary capacity, and Casely personally assisted at the QVMH when necessary.

In 1958, Elma became the first president of the Physiotherapy Society of South Australia, which was established to encourage research in the profession, and in 1959 she was invited to speak at the Third International Congress of the World Confederation for Physical Therapy in Paris.

In 1966, she was invited to become consultant editor for the Australian Journal of Physiotherapy, and from 1945 to 1969 she was a member of the board of studies in physiotherapy of the University of Adelaide.

She retired from the University of Adelaide as head of department in 1964 and in the same year was awarded honorary life membership of the Australian Physiotherapy Association (South Australian branch). Casely served the branch for 18 years in many capacities.

More recognition came in 1972, when she was awarded the first honorary life membership of the Obstetric Physiotherapists Group, and in 1984 when she was made an honoured member of the National Australian Physiotherapy Association.

She is held in the highest regard by physiotherapists throughout Australia for her enormous contribution to physiotherapy education and practice, and for her special personal qualities that endeared her to colleagues and patients alike.

She never sought personal recognition, but in 1965 she was awarded membership of the British Empire for 'outstanding services to physiotherapy over 38 years'. In 1981, her former students and colleagues honoured her by establishing an academic prize in her name which is awarded by the University of South Australia.

There are many accomplished academics, but not all of them try to educate men and women to serve the community. Casely taught her students by example to be tolerant, to respect the views of others no matter how much they differed from one's own; she never attempted to force her opinions and ideas but encouraged people to develop a sound sense of values by their own efforts.

Her generosity was limitless. She did so much to alleviate the suffering of starving children, ill-treated animals, refugees, the lepers, the blind and others in India, ex-prisoners, alcoholics and drug addicts - and to help the lonely, the neglected and the rejected. She herself had been deaf since her early 20s.

Her love of people was universal and unconditional. She will also be missed for her wisdom, wonderful sense of humour and her spiritual understanding and support.

She never married and her sisters pre-deceased her.

Marie Hammond
Jeanne-Marie Ganne
Alison Kinsman

John Ferguson Pritchard

John Ferguson Pritchard, MB BS, LRCP, MRCS, DRCOG, was a Guy's man, as were his father and brother. He was the younger son of George Brentnall Pritchard, elected FDS, RCS, LRCP, MRCS, Consultant Dental Surgeon Emeritus, Guy's Hospital (1920 - 1954) and former Chairman of the Dental Council.

During his time as a student at Guy's, John played Rugby for the 1st XV and gained his Half Blue, thus continuing his interest in sport, which was established in his school-days at Epsom College, where he played Rugby for the 1st XV, Cricket for the 1st XI and was Captain of Fives.

His first post after qualifying was that of House Surgeon at Orpington Hospital, after which, he went to St Nicholas Hospital, Plumstead, as House Physician. He gained his DRCOG after experience in Obstetrics at the Sussex Maternity Hospital and in Gynaecology at Shoreham Hospital.

Following his marriage in 1955, to Lois Daphne Mills, daughter of Air Commodore R L and Mrs Mills, he became a partner in a General Practice in Great Barr, Birmingham. Although not officially appointed Mines Doctor, he was frequently called to the Hampstead Colliery, West Bromwich, when accidents had occurred.

He returned south in 1960, to a General Practice in Bexley, where he was in partnership with Dr Cyril Morgan, until the latter's death in 1968. John then continued to work on alone in the practice they had built up together. He did this with outstanding success, ably supported by his wife, who looked after the administration. He gained a great reputation, by being always available to his patients when they needed him, as well as by delivering many babies at Bexley Maternity, Russel Stoneham and Hainault Maternity Units, all closed now as a result of reorganisation in the Health Service. He lived for his work and nothing gave him more pleasure than to attend at the safe delivery of a healthy baby of one of his patients.

Soon after he began his single-handed practice, he became ill with the initial attack of Multiple Sclerosis, with which he had to contend for the rest of his life. Fortunately, he suffered only minor attacks of the disease up to about 1989, when they became much more serious, leaving him considerably disabled, so that, in 1990, he had to accept that retirement was inevitable. He also suffered from the spread of a Malignant Melanoma, which ultimately did not respond to chemotherapy. Even then, he refused to be house bound and acquired a small electric

buggy, on which he would make his way to the local shops, where he could meet many of his former patients, who would stop to chat with him.

Gardening always gave him great pleasure and even when walking was difficult, he would still do his best to keep his garden up to the standard he had set himself.

He joined the BMA as soon as he qualified, but was never an active member, although always willing to lend his support when it was needed. He was an enthusiastic member of the old Epsomian Masonic Lodge No 3561 for over 20 years, taking his turn to serve as Master. Failing health, vision and hearing prevented him from taking an active part in the Lodge in his later years, but he was immensely proud when his son, Huw, entered the Lodge and later became Master.

John died on February 20th, 1995, leaving his widow and two sons, Huw and Robert, and three grandchildren, to whom we extend our deepest sympathy.

E C Dawson

United Clubs Report

This years committee now has only two months in office and the elections have already been held. Although fewer candidates stood than last year the team will be a strong one lead by Tom Witcher who has completed two years of BDS and a BSc in Plasma with Psychology. Silly Billy Ben Challacombe and Kieron Rooney will be the Vice Presidents and Richard Worth is appropriately named to be treasurer. This years main objective has been to gain better communication and a tighter degree of financial control over the individual clubs in an attempt to stem the £40,000 overdraft which has been developing over the past few years. This mini project was started with great hope and ambition until I realised that the sports rep was decerebrate and possibly the 'missing link' that anthropologists have been searching for all these years.

We have at last regained a minibus which is in the process of being thrashed to bits by our skilled minibus 'reverse-gear rally' team, captained by George Tsolakides and co-driven by Horace. Recently Ben and I have been involved in making suggestions for the planned refurbishment to the ground and first floors of Boland House which have not seen improvements in 30 years. The spit will be decorated more aesthetically and we have proposed that it should be given a sort of relaxing, 'cafe-esque'*(sic)* atmosphere (to keep up with the trends set in Philip Harris House, although I don't think the Medical School will be spending £250,000 on palm trees), possibly to stay open into the evening. Plans also include the provision of a sports administration room, an advice centre, showers in the 1st floor lavatories and the reopening of the ballroom as a large multipurpose area. We are closely involved in the ULU Medical Group campaign to have the student loan allocation raised for clinical students. This has already taken the form of presenting a petition to Downing Street and lobbying MPs in the Palace of Westminster. Simon Hughes MP has lent his support by offering to arrange a meeting with the education minister responsible for the student loans. Let's keep our fingers crossed.

We hope to make the remainder of the Summer term as merry as possible, despite the gloom of exams, by laying on various events....

Path + Obs 'n' Gynae party on 8th June, Final Year Dinner on 23rd June, Summer festival on 24th June, Reception for Dental Finalists and Clin Pharmers followed by the mother of all hops on 30th June and the Summer Ball on 1st July, which has already sold 2500 tickets.... copious back patting for Neil Cleaver and his helpers Jess, Katrina and Susan! Very best wishes to all

those involved in finals of one sort of another - most of you in other words - join in with all the end of term events, have a tremendous summer and return in October to do all sorts during Freshers' Week.

Ollie Harley

Guy's Hospital Rugby Football Club
End of Season 1994, The 150th Season

UMDS Boat Club

UL Head

WON: Ladies senior college VIIIs
Mens novice college VIIIs

Howling wind and rain set the scene for the club's first big Head race, held on 11th Feb. All of our regular crews entered, each looking to do well against their opposition. It was also the first time that our freshers raced over a long course, from Richmond to Chiswick. Another novelty was that UL had allowed entries from open and senior 2 club VIIIs, the event being restricted to crews from the University in years past. The men's first VIII were the first of our crews to row, setting off fifth in their division (Senior college VIIIs), chasing the Royal Free. After turning in the river, we set off in hot pursuit, the Free having opened out a ten length gap before the start line. Powering away at about 32, we rapidly left our chasers, St George's, for dead, and began to close down The Free. Settling the rate at 30, cox called for three pushes which saw us move closer every time, until by Chiswick Bridge, we had overlap with the boat in front. A time of 12mins 49secs was recorded, enough to finish third in our division, 9 seconds behind UCL and only 16secs behind the formidable Imperial College crew. The final results showed that had we entered senior 2 club VIIIs, we would have won; our time was good enough to beat all six crews in that category, as well as six open club VIIIs - very encouraging given that we had started rowing in a completely different boat the week before, so our novices could use our boat. (For interest, the nearest Hospital crew was over half a minute slower and St George's posted a time identical to our ladies first VIII!!).

Whilst the whole of the first VIII were happy with our credible performance, greater joy was had from the news that our men's freshers had won the novice VIIIs division, in a time of 14mins 21secs, beating their nemesis of the sprints, UCL. Despite changing the crew order, their row was solid and powerful, leaving UCL to trail in second, and beating their nearest hospital rivals St. George's by a whole minute; a great confidence booster for this keen, committed crew. Unfortunately, the ladies freshers were forced to row in a very heavy 25-year-old boat, as there was no modern one for them, and whilst gallantly trying to burn for the finish, the Imperial College ladies novice VIII blatantly steered into them a couple of hundred yards from Chiswick Bridge. Protests fell on deaf ears, although a time of just over 16 minutes was very credible given the circumstances.

That left the ladies first VIII, racing for the first time together at full strength, setting off in hot pursuit of UCL. Constant encouragement from their cox saw them erode away UCL's lead, and they caught and passed them just past Kew rail bridge. Coming off the water, the crew were confident of

having recorded a fast time, although news that Oxford Brookes had also swept past two opposition boats did cause a moment's anxiety. However, when the results were announced, UMDS ladies first VIII had won their division in a time of 14 mins 19 secs, beating the ladies of the Isis by four seconds, and leaving the nearest hospital crew (Bart's) a staggering one minute 10 secs behind.

Steve Arnold

United Hospitals Head: Feb 95

WON: Men's Open VIII
Men's Junior VIII
Women's Open VIII
Women's Novice VIII

The United Hospitals head race was rowed on Saturday 25th February on a sunny, but blustery day. UMDS entered five boats, including the mens second VIII, racing in their first Head of the season. The entries this year were slightly down in number compared to the last couple of years, but that didn't mean a drop in the standard of racing.

The race was held in two divisions, one for the more experienced crews, and one for the novices. In the senior division, all three UMDS crews were successful. The ladies first VIII, with one substitute, rowed powerfully and fluently to see off their opposition in winning the open VIIIs class in 15:18, re-affirming their dominance in the whole University, by beating their nearest opponents by a margin of 30 seconds. The mens second VIII did just as well: in their first race, after only three sessions rowing together this term, they recorded a time of 14 mins 03 secs - the second fastest time of the day. This was a remarkable achievement, beating every men's open VIII, except for that of their own club. Whereas the ladies and mens crews had had very good rows, that of the mens first VIII could only be described as 'good in parts'. Starting the race rating 34, we strode to settle the rating at 30. However, this was one race where the crew weren't quite going to gel, and the fact that we were swamped by wash from a motor cruiser around Kew Bridge didn't help matters. However, this gave us some new found resolve, and between Kew and the finish at Chiswick, we managed to pull about three lengths back on UCH who had started Head, and for the last third of the race at least rowed with some degree of cohesion, our power being maintained to the end. The time of 13 mins 37 secs was half a minute faster than UCH (our nearest challengers), although we know we can do better in future.

Being able to row in the newly repaired 'Orchard-Lisle' was a big boost to the ladies novice VIII, who went on to win their category by a huge margin of 51 seconds over nearest rivals St George's. This made up for the disappointment of the previous race where an uncompetitive boat and a collision hindered them severely. The men's novice VIII were not destined to do the

double this year either. Despite an excellent win in the University of London Head, the crew had two enforced changes, and had not practised for two weeks due to illness to various members. This manifested itself in a race which saw them finish second to UCH, recording a time of 15 mins 24 secs for the Richmond to Chiswick course.

As UMDS were running the United Hospitals Boat Club this year, many things had to be organised, and the driving force behind this weekend was again UH captain Andy Hobkirk. Many thanks are due to him for the huge amount of time and effort he has put in to organising this weekend. His team of helpers are also worthy of much praise: Ruth Selwood and Ollie Webber for acting as course martial and starter; Mr Michael Gleeson for his role as Chief Umpire and finishing judge; and vice-captains Matt Gray and Richard Baird for the many smaller (but just as vital) jobs carried out.

So far this season, UMDS has won all of the University and Hospital events held - best overall performing club at the UL and UH regattas in December (picking up both victor ludorum trophies), and winning most divisions at both the UL and UH Head races this month. The 1995 Hospitals Bumps beckon in May: come and support Guy's and St Thomas's most successful club at this event!

Kingston Head

Another regular date in the Boat Club's busy calendar is the Kingston Head, entered by three of our crews this year. A sunny day was enjoyed by all, the two womens crews looking to record fast times after their excellent showings in the Womens VIIIs Head one week previously.

Both first VIIIs had early morning outings at Kingston to re-acquaint ourselves with the course, and this helped to shake out some of our cobwebs. The race was promptly started at 2.00 pm, and the mens first VIII were the first to row, starting at position 55. A typically strong performance, rating 32, saw us catch two boats in front of us and pass the finish in 15:21, one and a half minutes faster than last year, and sixth in our category. Shortly behind us, the ladies first VIII had also rowed well, slicing over a minute off their time of last year, in recording just under 17 mins. The ladies novice VIII were the last of our crews to race, and they put in a solid and stylish performance which belied the fact that they have only been rowing for six months. In their division, they came a creditable fifth, finishing in a time of just over 18 minutes. Considering that we came up against crews including Olympic gold medallists, we took heart from our performances, and will work hard in our training in the coming weeks to improve on our shortcomings.

Steve Arnold

City of Bristol Head

WON: Mens coxed fours
SECOND: Mens senior 3 VIII
Ladies novice IV+

The City of Bristol head was rowed on 5th March, and the mens boat club had long planned this as their first tour of the season. Saturday morning saw us at the boat house loading boats and also 'persuading' five of our ladies novices to come along as tour guests. After initial reluctance, and a great deal of coercion from the men, they agreed that a trip to Bristol was perhaps more favourable than a weekend of revision!

We arrived in Bristol early in the evening. After leaving our stuff at the youth hostel, we went in search of a nice quiet pub, to commence our race preparations. Needless to say, some people were prepared a great deal better than others by the time it came to eat. Returning to the youth hostel by curfew time (just), it was destined to become the evening that Alex Setchill was destined to lose his fronds of hair, thanks to Dharmesh and a little help from the rest of the tour party.

Sunday morning dawned fine, but blowing a gale, and we set out to the docks to put the boats together. Sudden realisation that the fresher women's four was racing in twenty minutes time, saw their boat being put together in a record time. While the women were paddling to the start of the course, the men took up their traditional position on the dock side, to cheer our support. The ladies had a good row, coping admirably with the headwind that everyone encountered, and crossed the finishing line in 18:59, good enough for second place, and beating several boats that would have been expected to finish much higher. They were followed in the next division by the mens coxed four, again a scratch crew, who powered down the course in 14 mins 02 secs, to win their coxed fours category, comprehensively beating Kings by 40 seconds. Indeed, they were only four seconds behind the winning coxed four, three categories above them. The final division saw our third scratch crew, the mens VIII, racing in wind that blew the boat to a complete halt during part of the race. Nevertheless, a time of 13:02 was sixth fastest overall (ranking second in senior 3 VIIIs) - not bad for a crew made up of two first VIII, four second VIII and two fresher rowers.

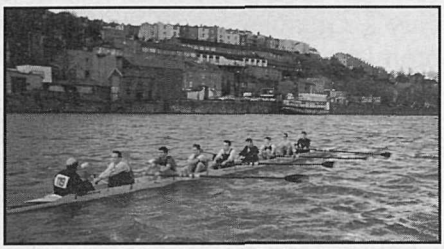
After the prize giving, the party loaded our trailer, and went off to celebrate a great weekend. Last but not least, special thanks must be extended to Howard Wright for his expert towing of our boats; the women also have special thanks for him, although why they want to rename their boat 'Howard's Pants' will forever remain a secret.

Crews: Women's four: Lucy, Meg, Eloise, Ros and Janine;

Men's four: Dylan Jewell, Steve Lewis, Steve Arnold, Sidd Nene and Dharmesh Mistry;

Men's eight: Tim Williams, Alex Setchil, Dylan Jewell, Howard Wright, Andy Hobkirk, Steve Lewis, Steve Ar-

nold, John O'Leary, and Dharmesh Mistry.



Mens VIII at Bristol

Chess

Guys and St Thomas':
U-Knighted at Last

1994 saw the development of peace in Northern Ireland, but possibly more significantly, the rebirth of the UMDS chess club - which has laid dormant for thousands of years.

Pioneers such as Riki, Bob and myself have brought back memories of a time when men fought each other only with their intellect to protect them. (Now that is a frightening thought.)

Battle commences every Monday night at 8pm in Boland House. We managed to persuade the United Clubs to part with enough money to buy some sets and clocks. However, in the quest for fulfilment, we have come across many obstacles such as disappearing pieces, players and even opponents. We were even accused of asking for foam pieces so that beginners wouldn't hurt themselves!

Fortunately, these setbacks have not been able to diminish our resolve and our position is now stronger than ever. We played UCL, who we thumped 6-0, and we have now organised matches against other colleges. Our team is a desperate gang of scoundrels and vagabonds including chief spokesman Riki Trivedi, Bob Gerber, the token fresher Ben (who has a big mouth for one so young), Micky, Garry and Aninda - all good players - who mysteriously turn up for matches and not a lot else. Of course we can't forget our secret weapon, the Howitzer - Flemming, without doubt our best player.

We are all very interested in more people coming along to the club. Beginners will be taught how to play and players of every ability will be found an opponent of a similar standard.

Especially welcome is the fresher we keep hearing about with a grade of 140+. Where are you? Your college needs you!

PS. What ever happened to all the freshers who joined the club in the first week? If you're still interested, come along on any Monday and give it a try. At least come along and watch me lose!

Julian G Barwell

Death

Hill, Peter J, LDS 1944, FDS 1950. On 12 May 1995, suddenly. Husband of Pat (nee Blood) MSR 1950 Guy's.

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All feature articles should be approximately 1500 to 2500 words in length. Photographs and disks will be returned as soon as possible if requested. Authors are asked to supply a contact phone number in case of any queries that may arise.

Classified ads will be charged at £5 for 35 words and 15p per word thereafter. Changes of address will only be published if requested. There is no charge for this service, nor for annoucements of births, deaths and marriages.

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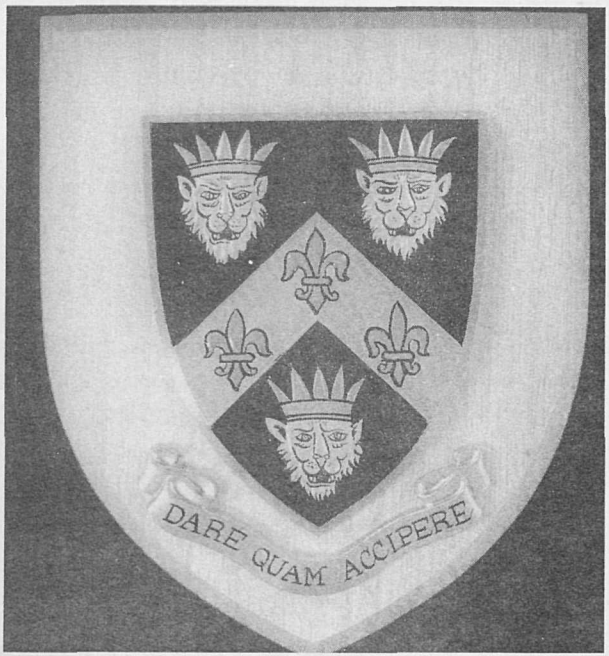

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UMDS Guy's
22 AUG 1995
Wills Library

Guy's Gazette

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Passim

Guy's and St Thomas' Trust has been published in the NHS League tables along with all other hospital Trusts in the country. The various categories by which each hospital is judged seem to many to lack insight into the running of a major hospital. It does not take into account many of those intangible qualities that are so intrinsic to healthcare provision. This lack of insight is something that we have grown accustomed to with the present government and is only another reflection of the chaos this country is steering towards with its strategies on health.

The medical profession has always been about altruism and should remain so. As a profession we must guard against producing a new generation of doctors where the pendulum has swung too far towards being the service provider with the maximum achievable efficiency and away from treating your patient as an individual and fighting for the best level of care.

Congratulations go out to the newly qualified doctors this June. It is hoped that they will stay in touch with the goings-on at Guy's and perhaps use the Gazette to that end. They have studied at Guy's and St Thomas' during a very interesting and dynamic period in the two hospitals' histories. It would be interesting to know how, if any, that has affected them. How has *the drive for efficiency* affected their altruistic outlook on medicine that was supposedly instilled in them over their academic careers?

Guy's has had a major face-lift in the Tower. All those weeks of endless drilling and workmen dangling precariously from the ceiling have paid off. An initial sceptic, one has been gently convinced that the new larger area is more aesthetically pleasing. The central rotating doorway takes only limited navigational skill and the several large pillars in the massive expanse of red carpet are bearable. All-in-all it is not a bad job.

It is with a tinge of sadness that I must inform the readership of the passing on of the editorship to another. Unfortunately one has to progress to newer pastures, but I know I will leave you in very capable hands. Mr Rikin Trevidi has all the right qualities for the job and I am sure he will entertain and inform you.

Over the past year we have been through some difficulties with regards to the future of Guy's. In some way it is hoped that the Gazette has helped to halt the progress of a ludicrous and mis-informed decision to close major departments of Guy's. The fight is not over and your support will be required over the preceding months. It is hoped that the Gazette will play a central role along with the many other organisations in being committed to securing the future of Guy's.

To Drink or Not to Drink?

Dear Sir,

Alcohol consumption should not be a behaviour that is ever required of staff or students (ie non-alcoholic beverages must always be available), but nor should it always be condemned. Social drinking is an established custom in our society and for the vast majority it is a source of pleasure that seldom has harmful consequences. Most societies have evolved customs and rules that maximise the pleasurable impact and minimise the harmful affects. There is no reason why UMDS should be any different. Societies function by the acceptance of implicit rules that are part of social mores and by compliance with legal constraints. It is the implicit learning and acceptance of social habits that has the most impact on our behaviour. Staff and students of UMDS are obviously part of the wider UK society and as such the majority of us have developed socially acceptable drinking habits. Are there any aspects of a medical school that do or should significantly change the situation? I would suggest that the following 'special circumstances' are worthy of debate.

1.What are the rules?

UMDS and the Guy's and St Thomas' Trust are currently drafting an alcohol policy, but until this has been agreed, nobody really knows. It is not considered acceptable for those on clinical duty (or on call) to be 'under the influence' - does this mean zero blood alcohol concentration? What about those lecturing, pursuing other academic activities, doing experiments?

2.What are the consequences of breaking the rules?

The more effective the punishment and the greater the probability of detection, the greater the compliance of the rules. The present situation of low probability and ineffective punishment will be of little deterrent value.

3.What are the social pressures from sub-cultures?

Here there is evidence of seriously conflicting messages. There are the senior clinicians who thought excessive drinking was all jolly good fun, and who emit a strong message that it is a way of 'being one of us'. There are those with medical risk concerns who feel that a medical school and hospital should take the lead in emphasising potential harm. There are those whose concerns focus around the economic consequences of excessive alcohol consumption.

These different social pressures mirror those in the wider UK society. There is no reason why an alcohol policy cannot accomodate these various

points of view. Drinking alcohol is fun and pleasurable, otherwise most of us would not do it. However, when abused it can, and does have harmful medical, social and financial consequences. It is our responsibility to devise a balanced set of rules so that the drinking of alcoholic beverages remains a socially acceptable behaviour. We cannot hope that students and staff will conform to our expectations unless these are made clear at both explicit and implicit levels. The minority who at present are drinking to excess and engaging in antisocial behaviour will not change until the negative consequences outweigh the positive. Unless clear and effective punishments are implemented the implicit message that it isn't really wrong will prevail.

Yours faithfully,

Professor S E File
Department of Pharmacology

Belsen Re-visited

Dear Sir,

It was such a shock coupled with great pride that I read the reprint of John's letter to you written in 1945 in the June-July Gazette.

During the present commemoration of VE and VJ days perhaps it is a good thing to read an account of the true horrors of war and the appalling conditions that faced people like John and his friends, indeed all our men and women of the three Forces.

Staying with our daughter Ann and her husband, then stationed in Osnabruck, in October 1978 we were taken to Berlin for two days. On granting a quiet wish from John that he would like to re-visit Belsen our son-in-law Anthony kindly drove many many miles to do just that. It was a most difficult place to find being un-charted then suddenly we came across the smallest of sign posts with one word Belsen. Below it the awful single track railway line. This we followed to the site. There were large gates with groups of uniformed Germans standing around - and there before us, surrounded by pine trees and an awesome, eerie silence were mound upon mound of heather. John walked straight in one feeling sure it was his hut.

At the foot of each mound a plaque stating the number of dead - hundreds - lying beneath each. We held hands, it was not the time nor the place for words.

As we left we were directed to the museum of photographs and memorabilia. Germans, I gather, are keen to keep precise records of everything.

John never mentioned Belsen again but he treasured a tiny shell given to him by a dying Pole - it was to say thank you for the care and comfort of his remaining hours. It was the Pole's one and only possession found in the sandy soil of Belsen.

Yours faithfully,

Ursula E Kilby(nee Dean)
SRN 1943-47

Dr Alfred Salter

Dear Sir,
Dr Salter died fifty years ago. A notice of a memorial service appeared in the Gazette of June-July. Readers might like to be reminded, or indeed to be informed for the first time, of the sculpted memorial to him on the Thames embankment near Cherry Garden Pier.

This charming work can be reached by taking a bus from the Gallerina past Tower Bridge, along Jamaica Road to Cherry Garden Street. A brief account of Dr Salter's life is displayed near the sculptures. For those who are unable to visit the site, and because the text is partially obscured as the result of vandalism, I have made a transcript. After viewing the site, return to Jamaica Road via Wilson Grove to see, on your left, the housing built as a result of the doctor's efforts.

Transcript of Text at Cherry Garden:

'Dr Alfred Salter was born in 1873 and started at Guy's Hospital in 1889. He visited homes in Bermondsey and was deeply impressed by the poverty and appalling housing conditions.

He took up residence at the Bermondsey Settlement, established a dividing insurance society which gave allowance to members during ill health and started a men's adult school on Sunday mornings. He upset his professional colleagues by charging only sixpence for medical consultations. Shortly afterwards he met Ada Brown and they married.

His daughter Joyce was born in 1902 and Dr Salter was elected to Bermondsey Council as a Liberal Whip and became a JP. By way of further proof of the sincerity of their commitment to the people of Bermondsey, Joyce was educated locally and not elsewhere. Later he resigned from the Liberals and joined the Independent Labour Party and formed, with fourteen others, the Socialist movement of Bermondsey. At this time the Salters' only child, Joyce, caught scarlet fever for the third time and died. This personal tragedy, which might have been avoided had Joyce been educated elsewhere, increased their commitment to the area and its people.

The Salters bought Fairby Grange in Kent and turned it into a home for Bermondsey patients. Dr Salter became MP for Bermondsey in 1922, the result being announced by London's first women mayor, Ada Salter. Mrs Salter aimed to have trees in every street and in two years 9,000 were planted. The Daily Telegraph at the time described 'an object lesson in what could be done to beautify even the poorest neighbourhood'. Through Dr Salter's efforts play facilities were established at Long Lane, at Tooley Street and at Tanner Street.

He prepared ambitious plans to replace 180 year old tenements with lower density developments, such as

Wilson Grove visible today adjacent to this site. At Salisbury Street 1035 people lived in only 155 homes, but after the Labour victory in the election of 1924 rapid progress was made. It was set back by the Conservative administration later in 1924. The new Minister of Health refused permission for the Salisbury Street plan for the second time, saying that some of the land must be sold for commercial purposes.

He campaigned for a solarium to treat tuberculosis sufferers of which there were hundreds in Bermondsey. The results speak for themselves. Between 1911 and 1935 the infant mortality rate fell from 160 to 69. In 1935 when 1487 babies were born not one mother died in childbirth.

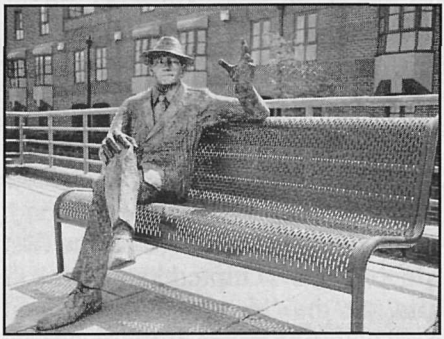
Dr Salter died on 24th August 1945 after a stroke.'

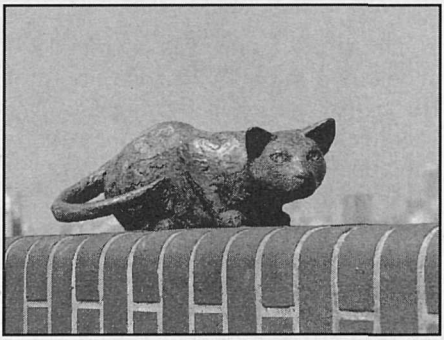
Diane Gorvin's sculpture shows the kind Dr Salter waving to his daughter Joyce, who is leaning against the Thames Wall. It is the daydream of an old man remembering happier times when his 'sunshine' was still alive. The cat on the wall completes the linear composition which utilises the length of the site. It can be seen in silhouette from Marigold Street and acts as a focal point for the sculptures.

Originally the figure of Dr Salter had spectacles but vandals have removed them.

Yours faithfully,

D W MacFarlane





Cryptic Clue

Dear Sir,

13 Across in the Times Crossword 19,835:

'Guy's memorial? A plot and his runiation.'

Virginia Bottomley's answer is 'A state-of-the-art centre for diagnostic day-care treatment and services' (Hansard 05.04.95).

Lambeth, Southwark & Lewisham Health Commision say it is 'An ambulatory care centre'.

The Chairman and Chief Executive of the Guy's and St Thomas' Hospital Trust say the answer is 'A centre for planned care'.

However, the crossword compiler, crossword enthusiasts, the staff and most people the world over know the correct word is 'HOSPITAL'.

Yours faithfully,

Phyllis M Hoffman

A Message From The New Chairman

Sir Kenneth Eaton has been recently appointed as the successor to Lord Hayhoe as the Chairman of Guy's and St Thomas' Trust. In a statement he applauded Lord Hayhoe for his tremendous efforts 'during a difficult transitional period'. His office will be established at St Thomas' but he hopes to familiarise himself with both sites.

He went on to say that, 'working together as a team, I am confident that we can fully satisfy the needs of our patients, and ensure that Guy's and St Thomas' Hospitals lead the way in the new NHS.'

NHS Performance Tables

In general the Trust performed well, gaining star rankings in all categories. Particular areas of excellence include A&E where the Trust obtained a 5-star ranking: in this category 97% of patients were assessed within five minutes of entering the Trust's two A&E departments.

A 5-star ranking was also gained in the cancelled operations category.

Day surgery rates also showed consistently high scores with all but one category obtaining 5-star gradings.

The most disappointing area was the outpatient waiting times category (percentage of patients seen within 30 minutes of there appointment time). The Trust gained a 1-star rating (70%), a 2% increase on last year's performance.

However, the overall poor ranking for this category conceals some excellent quality standards in outpatient clinics. For example, all therapies, paediatric and dermatology outpatients were seen within 30 minutes of their appointment time - which individually would have achieved a 5-star rating.

The Trust has placed a priority on developing quality strategies to improve waiting times in poorly performing outpatient clinics.

The Trust performed very well in the category for waiting times for first outpatient appointments within 26 weeks, with all but two categories receiving 5-star ratings. Six of the ten categories received 5-star ratings for first outpatient appointments within 13 weeks. No patient now waits for longer than 26 weeks for any outpatient appointment at the Trust.

In the elective waiting time category, general surgery has received a 5-star ranking for patients admitted within 3 months, although some special ties showed a slight drop of 1-star from last year's results. This has been as a result of the priority which has been given to long waiters to reduce waiting times.

Kidney Unit Moves

Renal services at St Thomas' will transfer over to Guy's in early September as part of the reorganisation of services currently taking place in the Trust.

Areas of renal care moving to Guy's include:

- Renal inpatient beds from Alice Ward
- Transplant unit
- CAPD department
- Home haemodialysis

The haemodialysis unit will remain open at St Thomas'. The department is moving to Guy's temporarily in order to build a new dedicated renal unit at St Thomas'.

The move follows the Secretary of State's approval of the Trust's recommendation that St Thomas' should become the site on which all acute services - including renal - will be based.

All St Thomas' patients have been informed individually by letter and further details will be sent to them shortly.

For more information on the move, contact Deidre Conn (Renal Business Manager) or Kerry Bartlett (Assistant Business Manager) at Guy's on ext 4151 or ext 4156 respectively.

New Trust Identity Card

A new Trust card will be issued to all members of staff by Group Directorates staring with an initial issue programme commencing Monday 24 July on the Guy's site.

The new identity card will combine a person's photographic image, name and department. An encoded magnetic strip will allow access to main doors equipped with card readers that will be introduced as part of the overall Trust Security Strategy.

The new card will clearly identify members of staff who are permitted clinical access to patients. Anybody permitted patient access will be provided a coloured badge.

Guy's Gazette Joins the Internet

The Gazette has recently accquired a home page on the internet. The world wide web address is: *http:www.umds.ac.uk/web-dox/gaz.html.*

Although the page is relatively limited at present it is hoped that this will expand with time, with regular news updates and other articles.

Paediatric Intensive Care

The Development of a Thriving Unit

The present complement of cots and beds for Paediatric Intensive Care (PIC) at Guy's is 21; this consists of 12 in Caleb which includes 2 cubicles for isolation, 4 in paediatric Russell Brock for Cardiology, and 5 in Arthur Farre for neonates from both the Guy's Maternity Unit, and where necessary, from locally, the region and beyond. Given the staff and the accommodation we never refuse patients. It is sensible for the premature newborn to have intensive care adjacent to the special care baby unit, but it does not make sense to have two other separate units 8 floors between them. However we are forced into this position, because had adult cardiac intensive care moved into Philip Harris House as planned, Caleb intensive care would have moved into Russell Brock, after modifications suitable for Paediatric Intensive Care.

I thought it might be of interest to trace briefly the gestation and birth of Paediatric Intensive Care and its subsequent progress.

Guy's

Up to about 1969 PIC was largely carried out in the Children's Wards Diplock and Caleb, situated in Hunt's house, and especially in Caleb where the Burns Unit was situated. In those days PIC was called high dependency, although much of the care could not have been more intensive.

Following major surgery, especially cardiac, prior to 1970 such children were nursed in the AICU (Cornelius Ward) usually by children's trained nurses, sent from Diplock and Caleb Ward, thereby depleting these wards.

For many years the Guy's Paediatricians had clamoured for a dedicated PICU, but we were told there would be one in the Tower, and we must be patient.

However, nobody could predict when the Tower would be completed, and with the agreement and active co-operation of Sister Crump, who was in charge of Diplock and Caleb Wards, and later Sister Jefferies, and Miss Titley the

Matron, we found the necessary funds (about £27,000) and partitioned an area in Caleb Ward for four acutely ill children; two of the beds were in cubicles. There was air conditioning with temperature control, which also serviced the Burns Unit.

'The major problem at first was the availability of nurses trained in paediatric intensive care...but gradually this eased, and more nurses were able to be recruited.'

The major problem at first was the availability of nurses trained in paediatric intensive care, and it was necessary at times to deplete Caleb and Diplock of their much needed trained nursing staff, but gradually this eased, and more nurses were able to be recruited.

There was no special opening of this unit by 'nobility', but Miss Titley took an interest in the project and gave it her support. However, when the unit was completed she told us that we could not call it Intensive care, because her budget could not stretch to the recognised 5 nurses per patient; but she promised 3 per patient, and we settled for 'maxi care', there being no choice. You can't have anything more than maximum!

The unit thrived, and during its first year we cared for 66 admissions covering a wide variety (1). There were 13 deaths, of whom 6 were neonates, and 4 were under the age of 2 years. The Sister in charge of the unit was Jean Spencer, with Sister Pamela Jefferies as Departmental Sister, and Dr James Appleyard was Paediatric Senior Registrar (currently Consultant Paediatrician in Canterbury) and was responsible for the day to day care. I believe I maintained overall supervision of the Unit, and an anaesthetist was on call for advice and assistance.

The Evelina

At the Evelina Hospital intensive care was carried out on the same lines as at Guy's, but there was no dedicated unit. However, during the early sixties, Donald Ross, Cardiac Surgeon, operated fortnightly at the Evelina, and one such patient underwent total correction of Fallot's tetralogy at the age of eight months, and was, we believed, the world's youngest survivor at that time (2). Post-operative intensive care for some of these cardiac children was carried

out in the theatre for the first 24 hours. This situation at both Guy's and the Evelina continued until the move into the Tower in 1976.

The Tower

Surprisingly, although some beds in Caleb Ward, and for cardiac work in Rothschild Ward, were allocated for intensive care, the nursing and equipment had not been planned in detail in spite of previous reassurances to the contrary. As a result, these resources had to be found in competition with the rest of the hospital, and the Evelina (the name given to the combined Children's Hospital) started its work in the Tower at a grave disadvantage.

Over a period of time, a part of Caleb was rebuilt, and an area for 4-5 beds allocated. Happily this had been made easier by the remarkable reduction in the incidence of burns in children, due to the recognition of the danger of paraffin heaters and inflammable clothing worn by young children.

During the ten year period from 1976, Mr Alan Yates, Cardiac Surgeon in charge of adult intensive care in Cornelius Ward (later renamed Russell Brock) agreed with the Evelina to allocate a part of Cornelius for 2 dedicated beds for Paediatric Cardiology, and this proved a great success, with its own nursing staff and special equipment, much of it donated by the Joseph Levy Foundation.

It was due in part to this rearrangement, that the Guy's Paediatric Cardiology Unit was designated supraregional (this indicated additional funds, ring-fenced for the inpatient care of infants). We were never sure that these funds were actually ring-fenced, and in fact found it difficult to understand how the Paediatric Cardiology Unit was accused of overspending in 1983, leading to the enforced closure of Rothschild Ward and four intensive care cots. This was a tragedy and lead to the founding of the Evelina Appeal in November 1983, and which still continues with success.

It was soon after this time that we started to plan an extension of paediatric Russell Brock from 2 beds/cots to 4. Negotiations were started with the Sportsmen's Aid Society, who most generously paid for the entire extension - at a cost of about £200,000.

The project was carried out with the agreement of many, in particular Mr Alan Yates, Professor Anthony Adams and his colleagues in the Anaesthetic Department, the senior nursing staff, and the technicians. The extension was opened in 1986 by Princess Diana.

The gain to the children was great, and under the devoted care of Sister Linda Holdway, Paediatric Russell Brock has gone from strength to strength.

The contribution to Paediatric intensive care by the Consultant Cardiac Surgeons, Donald Ross, Alan Yates, Phillip Deverall, and since 1991 David

'The contribution to Paediatric intensive care by the Consultant Cardiac Surgeons, Donald Ross, Alan Yates, Phillip Deverall... David Anderson, has been great...and with the contribution of pioneering Interventional Cardiology by Michael Tynan and later Shakeel Qureshi and Ted Baker has placed Guy's at the top.'

Anderson, has been great. The current surgical results are second to none, both in this country and abroad, and with the contribution of pioneering Interventional Cardiology by Michael Tynan and later Shakeel Qureshi and Ted Baker has placed Guy's at the top.

Equal support by the Consultant Anaesthetists has been forthcoming, together with all those others, such as technical staff and physiotherapists. I have already mentioned Sister Holdway, but in addition there have been numerous sisters and nursing staff who have passed through the unit, both those already trained, and those who voluntarily had a period in the unit while taking the postgraduate 13 month Paediatric Intensive Care Course.

In 1992 Guy's and St Thomas' first paediatric intensivist Dr Ian Murdoch was appointed, and Dr Michael Marsh in 1995. A retrieval service was set up by Ian Murdoch in 1993 and this is steadily increasing in numbers.

Finally, in early 1994, the Appeal Committee agreed to fund (at a cost of £175,000) the conversion of Diplock into an open plan, resulting in an increase in the number of beds/cots from 5 to 12, including 2 rooms for isolation. This project has been in operation since January 1995, and is already showing its value by being fully occupied at times.

Neonatal Intensive Care

Most commonly, this type of unit is attached to Special Care Baby Units (SCBU), and is used almost exclusively for the long term care of preterm babies; once off intensive care, such patients undergo progressive care in the

SCBU. The other type of unit is typified by that in Arthur Farre, which in addition admits sick neonates from the region and beyond who require intensive care.

In the early days, preterm infants were nursed in the Old Victoria Ward in Hunt's House. They were entirely the responsibility of the Maternity Unit, and cared for by midwives and the Obstetricians, with Paediatric advice if requested. At about the middle of the sixties this care was transferred to the Paediatricians, and with the opening of the Tower, with a purpose-built and enlarged SCBU in Arthur Farre Ward, the care was more complete. However, there were very limited intensive care facilities.

Fortunately, this was fairly easily corrected by combining a treatment room theatre unit with an adjacent student demonstration room. The former was no longer needed with the advances in the prevention of neonatal haemolytic disease. The conversion was generously funded by the Kings' fund, through Mary Thompson, the then Senior Paediatric nursing officer (3). The Unit was opened in 1978 with Barbara Nichol, Sister in charge of this five cotted neonatal intensive care unit together with the new adjacent SCBU. Although a demanding task, the care was humanely and successfully carried out until 1995 when Barbara Nichol retired.

'The unit has been a great success and many hundreds of neonates, now adolescents and adults, are alive and contributing to the welfare of the country and themselves.'

The unit has been a great success and many hundreds of neonates, now adolescents and adults, are alive and contributing to the welfare of the country and themselves.

A unique addition to the intensive care of the sick neonate has resulted from the initiative in 1980 (4,5) of Lindsay Allan who set up with Michael Tynan the first Fetal Cardiology Unit in the country. Since 1994, Gurleen Sharland (6) has replaced Lindsay Allan. This unit now has more than 2,000 mothers referred from Obstetricians and others throughout the country for fetal echocardiography, on account of the suspicion of a cardiac defect. Over the period of the last 18 months, 96 babies have been delivered at Guy's following the detection of a major cardiac problem in the baby in utero. Of these, about one half required surgery (or some form of intervention) during the neonatal

period. In many cases the parents had requested delivery at Guy's in order to avoid separation between mother and their newborn baby. Dr Sharland has emphasised that it is the mother's choice whether her pregnancy is terminated, and that the majority of scans are normal. Prenatal diagnosis means that parents and their carers may be prepared for the problem, resulting not only in the best possible perinatal and postnatal care, but also to provide reassurance to those with high risk pregnancies.

It may be imagined that Paediatric Intensive Care at Guy's has only been established on a firm footing in the face of difficulties, both financial and a lack of planning. This was despite the persistent pleas by the paediatricians, on behalf of the children and infants. Part of the problem is due to the relatively small numbers initially involved, but with the present increasing need, and the establishment of partnership between Guy's and St Thomas', the numbers of children requiring such care justifies generous funding for nurses salaries and others working in the unit, and for the best equipment, and the right accommodation. The latter is not to be judged by the average, nor by the maximum, but in numbers somewhere near the maximum. But perhaps better still judged by a thought about flexibility, perhaps contributed to by sliding sound proof panels, enabling a segment of intensive care beds to be used temporarily for non-intensive care or the reverse - just a thought.

Much of this paper has been based on my memory, (steadily decreasing!), and I should be glad to hear from readers for any corrections.

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I am indebted to Miss Phyllis Turnball (ex-Charing Cross Hospital) for repeatedly retyping this paper and to Miss Audrey Crump, Miss Pamela Jeffries and Professor Cyril Chantler for reading and checking the script.

Michael Joseph MD FRCP

Sherlock Holmes and the World Medical Literature: 1966 Onwards

Part 2: 1982 to 1992

1982

In 1982, Fitzgerald and Tierney published one of many such articles on the application of Holmesian methods to medical diagnostics (see also 1989, 1991 and 1992 sections). The other major medical article of 1982 about Holmes was by Caplan, and concerned the four stories in the Canon not narrated by Watson. Caplan remarked on how two of the stories ('Mazarin Stone' and 'His Last Bow') were told by an unidentified narrator because the plot depended on the knowledge of the reader (but not Holmes or Watson) of a conversation that took place between two villains. The two stories narrated by Holmes ('Blanched Soldier' and 'Lion's Mane') demanded Watson's absence as they involved essentially medical puzzles; Caplan expanded on these in a further article in 1983 (see below). In addition, Caplan outlined similarities he saw between the methods of Holmes and dermatologists: extremely close examination, often with magnification; occasional use of special laboratory techniques; relatively brief interview utilising trenchant questions; ability to make inferences from even limited observations; and delight at the sensory details, often cutaneous or at least external. This is probably the best evidence put forward for a specific association between Holmes and dermatology.

1983

In 'Blanched Soldier' and 'Lion's Mane', Caplan proposed that Watson's absence was necessary as the final elucidation required skill in dermatological diagnosis, such that the presence of a medic would have relieved the dramatic tension of the mystery too soon. In 'Blanched Soldier', there is little clinical detail to enable one to follow the detective's thinking process but this is not so in 'Lion's Mane'. The latter case concerned the death of a schoolmaster on a small sheltered

area of beach, not far from Holmes's retirement abode in Sussex. The victim exhibited a number of diagnostic skin lesions, with his back 'covered with dark red lines [with] angry weals curved around his shoulders and ribs'. The pain associated with the marks caused the victim to bite through his lips, and, just before death, this 'infernal agony produced a lethal systemic effect in which his breathing would stop for a time'. The victim's dog suffered the same fate on a later visit to the same place.

The cause of death was a giant jellyfish, but Caplan noted how Holmes was sorely taxed in interpreting the resultant lesions, which would have been simple for any dermatologist. Indeed, Holmes said that the problem was 'as strange a one as had ever confronted me', and that 'no [other] case ... brought me so completely to the limit of my powers'. Holmes was certainly unfortunate in his limited access to medical counsel during the case, as not only was Watson absent, but the story was set in a remote rural area, and 'the inquest had thrown no light on the matter'. Thanks to the book 'Out of Doors' by JG Wood (1874), however, Holmes was able to make the correct diagnosis. Interestingly, it was Wood's fancy that the jellyfish resembled a piece from a lion's mane - hence the title of the story.

1984

In 'A Study in Scarlet', Holmes describes to Watson a new test he has invented for detecting haemoglobin, to replace 'the old guaiacum test [which] was very clumsy and uncertain'. In fact, over a century later, the predominant test for haemoglobin remains based on guaiac and its related compounds. Recently, however, a new test, the HemoQuant assay, was described by Ahlquist and co-workers, which like Holmes's test 'measures haemoglobin and ... nothing else' with high sensitivity 'whether the blood is old or new'. As a mark of respect to Holmes, these workers proposed calling it the Sherlock Holmes test!

1985

In an article on 'The Resident Patient', Massey and Massey considered associations of the story with contemporary Victorian life. They suggested that Dr Percy Trevelyan in the story was a combination of the real-life figures Frederick Treves, best known for having brought to light the Elephant Man, and Dr Hughlings Jackson, arguably the father of English neurology. Consider these analogies: in the story, Dr Trevelyan was an author on 'obscure nervous lesions'. Mr Treves described a case of congenital deformity, an obscure form of nerve lesion. Dr Trevelyan's research into the pathology of catalepsy won him the Bruce Pinkerton prize and medal. Mr Treves won the Jacksonian prize of the Royal College of Surgeons. Both had difficulties with capital in starting up their

practices, and both had brilliant careers. Concerning the link with Dr Hughlings Jackson, Jackson was an authority on catalepsy and epilepsy (Jacksonian fits), as was Dr Trevelyan in the story. It is perhaps no coincidence that Dr Conan Doyle had worked at the London Hospital with both Treves and Jackson.

Further background material on 'The Resident Patient' may be found in a 1992 paper by Howard and Willison in the Sherlock Holmes Journal (SHJ), which presented some fascinating historical details regarding catalepsy, and the career of the distinguished Victorian neurologist Sir William Gowers. The authors proposed that Gowers may have been the model for Dr Trevelyan, on the basis of Doyle's likely knowledge of Gowers' work, and the possibility that Doyle may have attended a teaching session by Gowers. Though elegantly presented, however, their evidence is not as convincing as that given by Massey and Massey. On a smaller point of interest regarding the story, Howard Brody has discussed what led Trevelyan to use amyl nitrite to treat catalepsy; a rather unexpected treatment (Baker Street Journal, December 1976).

Returning to 1985 publications, Miller contributed to the corpus on how Holmesian deduction may be applied to medical diagnostics (see 1989, 1991 and 1992 sections), and, though not mentioned in the Medline database, Denis Smith published an interesting article in the SHJ concerning amongst other things a possible medical connection between 'Cardboard Box' and 'Yellow Face' - Cushing's syndrome. Smith noted how the surname of the three sisters in 'Cardboard Box' was Cushing, and how in 'Yellow Face' Mr Grant Munro beheld a 'shockingly unnatural' face from the upstairs window of a cottage. As the two stories were published consecutively, Smith proposed that a single article about the syndrome in a medical journal may have inspired Doyle with a family name for one story, and the starting point for the plot of another. This theory is credible (albeit at its bounds!) until one considers that Harvey Williams Cushing did not describe his syndrome until after the two stories had been published. Alternatively, could it be that Sir Arthur predated Cushing in the same way as he did Marfan (see 1975 section)?

1987

In the Spring of 1987, Richard Caplan published an article on 'brain fever', a condition which occasionally crops up in the Canon, for example affecting Percy Phelps in 'Naval Treaty'. Brain fever has always been a rather nebulous and medically doubtful diagnosis, and it is amusing to consider that Doyle himself once described the condition as one which 'always attacks the heroine after a crisis but which is unknown under that name to the textbooks'. Certainly, Caplan was unable to track down the condition in any of the medical textbooks until he came

to an 1847 work by Gunn with the title 'Domestic Medicine, or Poor Man's Friend in the Hours of Affliction, Pain and Sickness', which described 'nervous fever' as a condition which 'affects the whole nervous system and produces a tremulous motion of the body and limbs'. These and other descriptions in the book seemed to confirm that Percy Phelps in 'Naval Treaty' did indeed suffer from brain fever. Caplan concluded his article with a description of two letters written about Mr Phelps, which he found in a collection of material originally belonging to the great Victorian surgeon Jonathan Hutchinson, and which are now held at The Johns Hopkins Medical School in the United States. The first letter was written to Hutchinson by a Dr E Propter Hoak, asking for help with the treatment of Phelps, and the second written again by Hoak (or Hoaks?) to Holmes himself, dated 1 February 1890. The latter letter read as follows:

'Dear Mr Sherlock Holmes,

This letter is sent to you in my role as physician unto Mr Percy Phelps, who has been under my care these past eight months. We need your help, sir.

I remind you that Mr Phelps was just emerging from a most incapacitating bout of brain fever when you visited him at Briarbrae. He enjoyed a spectacular sudden recovery after that. ... I seek your aid not only because of your renown at solving arcane puzzles, but because in some strange way you seem to be a factor in his agonies. [In] each dream that awakens him ... he is seated at a table, a covered platter is set before him, the lid is raised disclosing a scroll of paper, which, when lifted, reveals your face smiling at him from the bottom of the platter... Awaiting your earnest reply, I remain, sir,

Yours earnestly,

E Propter Hoak, MB'

Also in 1987, Ehrenkranz, a member of the South Floridan Sherlockian society The Tropical Deerstalkers, published an article considering the appeal of the Canon to those interested in tropical infectious diseases. He concentrated on the story 'Dying Detective', pointing out how the character Dr Ainstree, described as 'the greatest living authority on tropical disease', seemed to be a clear reference to Patrick Manson, the author of numerous famous textbooks, and discoverer of the arthropod vector of filariasis. He moved on to discuss the nature of the infectious murder weapon in the story, and considered Yersinia pestis, which produces death by primary septicaemic plague, to be the most likely. Despite pointing out that plague would be unlikely to follow transcutaneous injection, as happened in the story, he recalled how it had successfully been used as a murder weapon in this way, by means of a jab in the upper arm, on a railway platform in Calcutta in 1933 (Wu et al., 1936). He proposed that the Calcuttan murder had been achieved not only by plague, but also by plagiary!

In another article published in 1987, Cherington proposed that Sherlock Holmes was, in spirit, a neurologist (see Figure). In support of this view, it is well known that Doyle had ambitions in neurology, and wrote a treatise on his completion of medical school on a major neurologic condition, tabes dorsalis. In addition, a large number of the medical conditions mentioned in the Canon are neurological. Concerning one of these conditions, Brill wrote a letter to the journal 'Neurology' criticising Cherington's (and Doyle's) diagnosis of St Vitus' dance in 'Greek Interpreter', and proposing Gilles de la Tourette's syndrome as an alternative. Tourette's original description of this syndrome was made in 1885, whereas 'Greek Interpreter' was not published until September 1893. Nevertheless, after reading a number of books written by Sir Arthur, Brill concluded that Doyle was not familiar with Tourette's work.

Figure:A wise career move? Sherlock Holmes and neurology (taken from Cherington, 1987).

1988

In 1988, Maltby published an article in the Canadian Journal of Anaesthesia on anaesthetic aspects of the Canon; an edited version of which appeared in the September 1990 issue of The Journal of The Arthur Conan Doyle Society. In his paper, Maltby noted how chloroform was the only general anaesthetic to be used with criminal intent in the Canon, in 'Three Gables', 'His Last Bow', and 'Lady Frances Carfax', and how Dr Watson's use of injected ether to resuscitate Lady Frances Carfax was puzzling, as she was already deeply anaesthetised with chloroform, such that adding ether would make the situation worse. Nevertheless, this was standard medical practice at the time. Opium was used for sedation and/or abduction in 'Silver Blaze' and 'Wisteria Lodge', and also appeared in 'Man with the Twisted Lip' and 'Sign of Four'. Morphine was administered by hypodermic injection in 'Creeping Man' and 'Illustrious Client', and curare was used as a murder weapon in 'Sussex Vampire'. Interestingly, Doyle appeared to confuse

the properties of morphine and cocaine in 'A Scandal in Bohemia'. Finally, as regards Holmes's personal drug use, Maltby noted how Watson described Holmes in 'Five Orange Pips' as a self-poisoner by cocaine and tobacco, but did not mention him being a user of morphine or opium.

In August 1988, Henry Rollin published a fascinating article in the British Journal of Psychiatry on the psychological make-up of Holmes. He noted how Holmes, as described by Watson, seemed to be an austere, solitary, self-driving individual apparently incapable of any conventional human emotional expression, as indicated by his aversion to women and disinclination to form new relationships. Indeed, elsewhere I have seen descriptions of Holmes as the sort of person one would feel uncomfortable with at a dinner party! Some authors have proposed that Holmes was a homosexual, but Rollin disputed this and considered Holmes more likely to be asexual. Certainly, this would fit in with his narcissistic, egocentric nature. One trait not noted by Watson was Holmes's obsessional nature, which Rollin proposed was a symptom of a frank neurosis. This view is supported by Holmes's tendency to bouts of depression, a characteristic of which is psychomotor retardation, so well described by Watson in 'The Musgrave Ritual': 'He would lie about with his violin and his books, hardly moving, save from the sofa to the table'. As mentioned earlier, however, such bouts of depression are not uncommon in men of creativity.

Regarding Holmes's cocaine use, Rollin proposed that, though a user, Holmes was not addicted, and merely used cocaine as a mood elevator. As Watson said in 'Yellow Face': 'He [Holmes] only turned to the drug as a protest against the monotony of existence'. In addition, there is no evidence that Holmes at any time suffered mental or physical deterioration, the inevitable consequence of prolonged cocaine use. As an aside, it is interesting to note that in the Summer 1985 issue of Baker Street Miscellanea, Robert Katz proposed that Holmes's and Watson's addictions to cocaine and betting, respectively, 'served to create a therapeutic environment ... that enabled [them] to deal constructively with potentially dangerous behavioural problems'! Finally, is Holmes a suitable case for treatment? In contrast to Musto's view of 1968 (discussed earlier), Rollin thought not, not only because removal of Holmes's obsessional preoccupation with detail would deprive him of his abilities, but also because anyone attempting to psychoanalyse Holmes could find themselves the victim of role reversal! Roberts (SHJ, Autumn 1974) has also discussed the personality of Holmes, concentrating on his likely upbringing and education, limits of knowledge, and philosophical beliefs.

Other scholarly discussion of Sherlock Holmes and cocaine has included articles by Jameson (1974) and Grilly (1980) in the SHJ. Jameson presented historical background regarding cocaine, and dated the period of drug use by

Holmes as 1882-90. This falls well within the period of cocaine's popularity in Britain, 1890 coinciding with the beginning of public awareness regarding the drug's hazards; even so, it was not until 1920 that cocaine was made illegal. In addition, Jameson proposed that during this period Holmes's cocaine use declined and was not continuous, and that at all times its use was harmless, being a substitute for the stimulation and excitement of the chase when no cases were forthcoming. As Holmes's career progressed and he became busier, his need for the drug diminished until it was ultimately abandoned. Grilly presented further background information regarding cocaine, and proposed, like Jameson, that Holmes was not addicted. In addition, he criticised Miller's article of 1978 (see earlier), which suggested that Holmes may have deceived Watson about his cocaine use, and was in fact injecting a belladonna alkaloid.

1989

In January 1989, Peschel and Peschel published an article in the Journal of the Royal Society of Medicine (JRSM) considering what physicians have in common with Sherlock Holmes. Re-iterating what was said earlier in the Background section of this paper, they commented that medical and detective work share a number of thought processes and drives, namely observation, analysis and deduction, devotion to detail, hard work, learning, energy, determination, and an overpowering desire to solve mysteries. This being said, I wager that other professions could equally justifiably make the same claims! The Peschels then illustrated, by means of three medical case reports, how an application of Holmes's methods could benefit hospital practice. They used a jigsaw puzzle analogy to illustrate how in the diagnosis of an illness one often does not have all the pieces.

1991

A further article in the same journal by Oderwald and Sebus two years later continued the discussion, with particular attention given to the problem-solving aspect. They criticised the Peschels' jigsaw puzzle analogy, proposing that such a metaphor arises from the neat pre-ordained nature of detective stories and medical case histories, in which a known outcome results in a reversal of time. To understand medicine in practice, they argued, one has to distinguish between what is happening in reality and the specific way in which reality is represented in a case history. Thus, final success should not be ascribed to the entire diagnostic process, nor should reality be reduced to one line of reasoning. Oderwald and Sebus proposed Umberto Eco's novel 'The Name of the Rose' (1984) as a better analogy of detection to medicine. In this novel, the protagonist, coincidentally (?) named William of Baskerville, attempts to solve a series of murders in a monas-

tery, the plot consisting of several parallel levels. Only one of these levels concerns detection per se, such that, despite William assuming a theological pattern to lead him to the solution, this turns out to be the wrong pattern, with the outcome not the result of what he thought. Rather, his mere presence at the scene seems to be more important. In addition, at the end of Eco's novel, there is no 'complete picture', but instead an open structure, which Oderwald and Sebus proposed as more analogous to medical practice than the jigsaw puzzle model. Certainly, it would be counter-productive to believe that a narrow line of reasoning could cope with the multifactorial nature of medical diagnosis and management.

In a subsequent letter to the JRSM, Ayers supported Oderwald and Sebus's William of Baskerville model of medicine, and referred to the enunciation by Eco and collaborators (1983) of the principles of ratiocination (Edgar Allan Poe's term) or abduction (Eco's preferred term), which are: 'Never assume anything; the nature of the object under scrutiny must dictate the nature of the inquiry; it is necessary to keep sight of the matter as a whole; and one must prove that crucial 'apparent impossibilities' are possible (if, indeed, they are so)'. This is surely the best representation yet of Sherlock's methods, and how they can be transposed to medical practice. Ayers concluded by saying that current work on computer algorithms and artificial intelligence as a means of handling medical decision making might prove to be a waste of time, and even counter-productive (see Gilbody, 1992), with the answers all in Holmes's methods.

In March 1991, in a further contribution to the neurological Holmesian corpus, Westmoreland and Key reported how, after reviewing the Canon, they found 41 (73%) of the 56 short stories, and all four of the novels, to make some reference to a neurological condition or symptom. Consequently, the proposal was made, not for the first time by a medical specialty, that neurology has more right than other specialties to lay claim to Holmes. Indeed, Holmes himself in 'Mazarin Stone' said: 'I am a brain, Watson. The rest of me is a mere appendix'. Personally, however, I believe that we all have something to learn from Sherlock Holmes, whether or not we are neurologists, and this is surely why Sherlock has had such a wide-ranging and long-lasting cultural impact.

Finally, it is perhaps appropriate to mention a brief item which appeared in the August-October 1991 issue of The Sherlock Holmes Gazette (no2, p32) concerning the plaque in the pathology museum of St Bartholomew's Hospital in London, where Holmes and Watson reputedly first met. This plaque was put up by The Baker Street Irregulars in 1953, and is still visited by half a dozen or so visitors each week. Dr AG Stanfeld, whose office happens to contain the said plaque, does not seem to object!

1992

In the June 1992 issue of JRSM, the Canadian anthropologist Joel Wilbush criticised the Peschels' use of Holmes's methods as a model for the diagnostic process (1989 section), even when a multi-levelled approach is adopted (Oderwald and Sebus, 1991). He pointed out how medical diagnosis differs in both content and circumstances from detection, being principally a social process rather than an objective exploration. He further suggested that, unlike a detective who identifies unknown agents, a doctor is usually familiar with his patient and the likely disease scenarios, and so can often make diagnoses 'like a 'blacktracker' identifying spoor left by a familiar animal', rather than by deductive analysis! Wilbush thus concluded how the role of older more primitive parts of the brain in the diagnostic process remains under-appreciated.

Wilbush's comments certainly provide food for thought at the highest cerebral level, but are perhaps not surprising from an anthropologist. Moreover, I would question the view that 'instinct without knowledge' could recognise dysdiadochokinesia or diagnose phaeochromocytoma! Diagnosis is not mere recognition; it is an intellectual process, coming into play when the nature of the disease is not immediately apparent. Nevertheless, he does have a point in that medicine is much more than just a series of deductive steps. Unlike detection, management in medicine begins rather than ends with the diagnosis.

Despite being true, these views, firmly rooted in the principles of holism, are I believe rather unfair on Sherlock Holmes, who selected interesting cases 'for the quick analysis of cause and effect which gives the charm to an investigation'. When asked by Watson in the story 'A Case of Identity' how many cases he had on hand, Holmes replied: 'Some ten or twelve, but none which present any feature of interest'. In other words, deductive analysis, though interesting for the reader, played little part in most of Holmes's cases. I would propose that this is also true for medicine, however much doctors may like to think otherwise!

In the Journal of the American Academy of Dermatology, Caplan discussed the links between Holmes, Doyle and Malcolm Morris, a famous dermatologist and friend of Doyle. The article was principally about the dermatological contributions of Dr Morris and his link with Doyle. It was Morris, for example, who suggested that Doyle become a specialist and move to London, and that he should write a book about a detective, and give up medicine for writing. In addition, Morris proposed 21 Baker Street, where his grandfather had lived, as Holmes's abode, and Doyle visited and went over the particulars of sale of that house, getting to know every detail of it - which he then used in the Holmes stories. It was in case the residents objected to the use of their address that Doyle invented 221B. Finally, in the preface of one of Morris's books, drawing on material from Sir

John Simon's book 'English Sanitary Institutions', Morris acknowledged Mr John Murray, the publisher of Simon's second edition in 1897. Caplan thus proposed that we may now know what happened to Murray, the faithful orderly who helped Dr Watson escape after his wound at the battle of Maiwand (this sort of thing is very interesting for us Holmesians...!).

The only other significant reference to Holmes in 1992 was a letter by Danek and co-workers to the journal Archives of Neurology, supporting Westmoreland and Key's 1991 article, and re-stating the importance of Holmes's 'science of deduction' in determining his popularity amongst the medical profession. It is reassuring to note that this popularity is not only undying, but seems currently to be increasing.

Concluding Remarks

Sherlock Holmes has inspired and stimulated the medical profession probably more than any other fictional character, not least because his adventures reflect so well and describe so vividly contemporary Victorian and Edwardian medicine. As a result, Holmes continues to be a subject of active debate in the medical literature, which happily appears to be increasing. The recent arrival of readily accessible CD-ROM and other databases, such as the one used in this study, provides great research opportunities for those interested in the serious study of Sherlock Holmes and Sir Arthur Conan Doyle - not to mention other great historical figures. It will therefore be interesting to see if others 'grasp the nettle' as I did. There are gems waiting to be found, a recent Sherlockian one that springs to mind (in the general scientific literature) being a witty article about Professor Moriarty in the New Scientist magazine (Bowers, 1989).

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John S Gilbody

...and life hereafter ...

Your Career: A Look Beyond Finals

Where do you go from here? Well it helps to know where you are going if you are really trying to plan a sensible route, and before you decide on that you need to reflect where you could go. One blessing of the medical degree is that it opens up a huge range of careers-within-a-career, more varied than many imagine. Although almost half the doctors qualifying will end up working in hospitals, and almost half will become general practitioners, some 10% will do neither, being in industry, journalism, the services, public health, directing plays for the National Theatre, or whatever! As you look around acute hospitals you can also see very many sorts of practice, some very interactive with patients, some 'hi-tech', some relaxed, some frenetic. So no-one should feel constrained as to ultimate choice: it's an exciting professional world out there.

Where does one start?

It helps to decide fairly early, certainly by the end of the pre-registration year, the broad direction one is moving in: medical/paediatric, or surgical/O&G, or general practice, etc. By choice of the right posts or rotation schemes you can keep several options open while you gain more experience, so it is well worth getting good advice at this stage. District Clinical Tutors, or here at UMDS the Postgraduate Departments, and College or Specialty Tutors are around and usually very willing to help personally or put you in touch with the right people.

Does this 'Calman Report' change all the rules?

The Calman Report is indeed quite radical in its proposals, and some people have been sceptical as to whether it can work before the major consultant expansion has occurred. However, the writing is on the Department of Health wall and we think it is undoubtedly going to happen somehow, some time, and

almost certainly soon. But it is all about specialist training for future consultants.

So what about training for general practice?

GP training is not affected: Vocational Training Schemes will continue, in parallel with individual programmes of SHO posts of the type recommended by the RCGP, and traineeships in general practice. This usually takes around four years from registration to completion of training to a level at which you are eligible to become a Principal in General Practice.

Back to Calman - what is going to happen to specialist training?

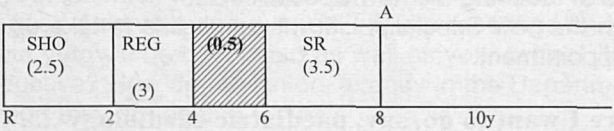
The diagram should help (see Figure). Current structures and 'post-Calman' structures are shown, with an illustration of the changes that research can make. The amount of time spent in research varies both within specialties and between specialties, but more about that later.

Key features of the post-Calman world are:

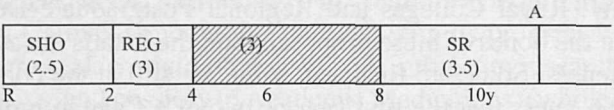
- Disappearance of unconnected registrar and SR posts, these being replaced by appointments within a unified training grade of Specialist Registrar to a formal training programme of posts. Where there are now rotations, usually at either registrar or SR level, there will be progressions within the one programme and the one grade.
- Entry to this Specialist Registrar grade will be 'selective' or 'competitive', and will require - as decreed by the relevant Royal College - a minimum duration of appropriate experience, typically at least 2 years as SHO in a specified range of posts, and the passing of a first level examination (e.g. MRCP).
- An important feature of the new programmes will be the quality criteria imposed on the posts which form parts of the programme: legal hours, good conditions of work, protected time away from clinical duties for training, active support and appraisal by trainers, this enshrined in Educational Contracts (of which we in this Trust and UMDS were among the pioneers).
- On entry to a programme, the specialist registrar will be assigned a unique National Training Number (NTN), which locks him or her into the training system, and which can be retained while some other approved activity such as research or working abroad takes him or her out of the programme temporarily.

CURRENT STRUCTURES

'research-light'

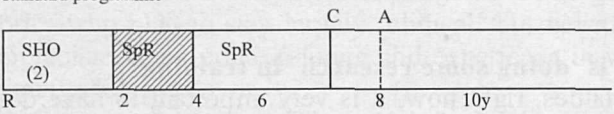


'research - heavy"

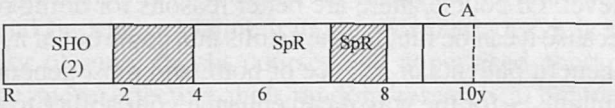


CALMAN PROPOSALS

standard programme



academic "track"



KEY

R = Registration
C = CCST awarded
A = Appointment as consultant
SpR = Specialist Registrar grade
( ) = median years in grade
□ = research activity

Diagram of typical training patterns in hospital specialties now, and after Calman Report takes effect. There are differences between specialties, and between individuals within specialties. So the above is a much simplified model.

- A Certification of Completed Specialist Training (CCST), recognised throughout the European Community will be issued at the end of satisfactory completion of the programme, and this will become the usual way for UK graduates of reaching the new Specialist List.
- Only those on the new Specialist List will be eligible to take up an NHS Consultant Appointment.

So if in the future I want to do, say, paediatric cardiology .....

There we cannot really help you yet, or anyone asking for detail for any particular specialty. Royal Colleges and Regional Postgraduate Deans are busily fleshing out the bones of these proposals, and the details are at various stages of completeness. Some are finalised, some are still at the contentious draft stage. We can guess that the first year or two of a Calman programme will look much like a current registrar post, but with more of those quality criteria in place. What happens later in the programmes, or after the CCST when people should be getting consultant posts, if they do not, no one knows yet.

How important is 'doing some research' in training?

For some specialties, right now, it is very important to have done some research and have some papers on your CV if you are to get that next post, especially at SR level. Of course, there are better reasons for doing research: for the fun of it, because it can be fun; for the results that come out of it, because those results can benefit patients or science or both; and most generally - for all - 'trainee consultants' - for the way it can enhance your ability to evaluate critically other people's research when that bears upon your everyday clinical practice. Sadly, there is a down side. Trainees can get trapped into research which is not fun, which is not scientifically or clinically worthwhile, and which is so unsupervised as to be of little educational benefit.

As things are now, a few simple rules apply:

- Find out what is expected in this regard in your specialty of choice. Is it essential? Can it be done within the clinical post? Are you expected to take a year out? Or two? Should you aim for an MD, or an MS? There are no general answers, so seek good advice from Tutors and those in the field to work out what is good for you personally.

- Don't come out of clinical posts too early: you need to be clinically 'credible' to do the best research, and to get the best out of it, and to get your next post after the research assignment. Again if in doubt, take advice.
- Do your research with a supervisor or a Department where you will clearly get good guidance and support, regular meetings and supervision, and where you will be developed as well as your project. Is the Department productive? How do the juniors already in the Department feel about the support they are getting?

Calman, research, and careers in Academic Medicine

A post-Calman structure for training, with its programmes, and its NTNs, and its timescales, could obviously pose a threat to research attachments and Fellowships, and possibly to Academic Medicine as a whole. Kenneth Calman himself, however, and his Report, and a recent 'Supplementary Report' on this topic, all address the issue constructively. What emerges is a preparedness to be flexible in regard to the needs of those individuals who are keen to work towards being a 'clinical academic', and imaginative in regard to the needs of the majority who plan to stay largely 'clinical' but nevertheless need, and would appreciate, appropriate training and experience in what you can call research methodology.

For the former, it is suggested that some academic training tracks, special Calman programmes if you like, are designed to allow space and time for deeper and broader academic training. For the latter, it is suggested that the possibility of more taught courses and supervised short research projects would be more effective than random research assignments. Certainly at UMDS, and we will not be alone in this, we will be looking for those academic tracks for our Clinical Lecturers and some Research Fellows, and we will want to meet those more general needs by the development of more MScs in clinical subjects. Several are in existence and others are being developed now, e.g. in Endocrinology and in Rheumatology.

Where can one get more information?

Locally, as mentioned, from your hospital's Clinical Tutor (at Guy's and St Thomas' that's the Postgraduate Dean or Sub-Dean or Dental Postgraduate Tutor), College and specialty tutors, and informally the consultant(s) you work with or consultants of the specialty in which you have an interest. Each Royal College has an office dedicated to postgraduate affairs, who can answer

specific queries about progress on their College curricula and programmes and may send you relevant information. The BMA has a Careers Office, and will shortly be publishing a new edition of their useful small paperback on Medical Careers A General Guide.

The Calman Report 'Hospital Doctors: Training for the Future', September 1993. HMSO, London

Brendan Hicks
Postgraduate Dean

Modern Fairy Stories

The contact

James Snubbage used to play a silly game when he was younger, a game which put him in contact with the people of the world, and which was always discovered by his parents, no matter how discretely it was carried out.

Some readers will have guessed that the game involved the telephone, and was discovered by his parents because of the resultant bill! When his parents were out, James would slowly dial a random series of numbers until a dialling tone could be heard. Often, no connection would be made, of course, but that was part of the gamble. Occasionally, however, his call was connected. In this way, he had heard many strange dialling tones, listening, if someone answered, for a few seconds to that person, perhaps speaking in a foreign tongue, before quickly saying hello and replacing the receiver. He was enchanted by the idea of chance, that someone in the world, before he even started dialling, would receive his call. He sometimes wondered who that person would be. Male or female? English-speaking or not? And what sort of voice? Before he had even been born, he felt his life had been destined to contact that person, albeit on a temporary basis.

'And it was during a solitary session playing this game at his father's desk, that James had a remarkable idea.'

And it was during a solitary session playing this game at his father's desk, that James had a remarkable idea. Why didn't he dial himself? He knew from when his parents had done this that the line should be engaged, but he was in a particularly hopeful mood, and still at that time in life when reality and the unknown are linked tenuously in the mind. So it was that he carefully, almost automatically, rang himself.

He was mildly surprised when he heard a dialling tone, but almost dropped the receiver when the call was answered.

'778-1275,' came the reply, 'James Snubbage speaking.'

That incident had ended James's time-killing game, nearly five years earlier, and now had re-entered his thoughts during the long holiday with little to do that separates A-levels from the start of University. He was starting at Guy's Hospital (sorry, UMDS or UMDKS or whatever) a few days later, at the end of September, and wondered if he might try to ring 'home' again...

James dialled 7-7-8-1 and then slowed. He thought 'What if?' After a short pause, he continued, dialling 2 and then 7, and, after a moment's hesitation, 5. Almost immediately there was a reply.

'Hello, 778-1275.' The voice was that of a young man, undoubtedly of a similar age to James.

Shakily, James asked: 'I-Is that James, James Snubbage?'

'Yes, that's right,' came the reply.

'Uh, I know this may sound a little daft, but I am James Snubbage. So how can you be?'

'Look, I don't know who you are, but this is a very immature joke, and I don't appreciate it. '

'Look, I don't know who you are, but this is a very immature joke, and I don't appreciate it. I'm starting at University soon, and I'm trying to get everything sorted ready for leaving home. Goodbye,' the voice continued.

'No, wait,' James implored, 'I'm serious. Do you live at 16 Wootleridge Gardens, Sydenham?'

'Anyone can use a telephone directory, friend, although we are -er- actually ex-directory. I don't suppose you have any way of proving who you are?' the voice asked.

'Wait a second, you have a burglar alarm, I bet,' James challenged.

'Yes.'

'Well, don't you hide its keys behind the silver clock on the mantelpiece?'

'How the Hell do you know that?' the voice demanded.

'I don't know. Do you?'

The conversation continued in this vein for a few minutes before both were finally convinced that either they were the victims of a staggering coincidence, or were the participants in an equally staggering phenomenon.

It transpired that James's 'double' was starting at Keele University in Staffordshire to study Law, at about the same time as James was starting at Guy's. James thought 'Why the difference?'

The voice made a comment.

'I propose that we exist in parallel Universes, and that somehow a break has occurred in the fabrics of these co-habiting realities. I really see no alternative. I remember reading about it...'

James interrupted. 'I don't suppose you can remember a call about five years ago when the line went dead, soon after you lifted the receiver? It was when I first contacted you.'

'Funnily enough,' the voice replied, 'I had a similar experience at about the same time. Thought it was quite peculiar. Put it out of my mind, though. I mean, think of how many strange notions and experiences children leave behind as they mature, and simply forget.'

'What puzzles me, James,' said James, 'is how, when we seem to be identical in lifestyle and person in every other way, we are embarking on different careers? Surely, this means there are some differences between the twin realities we seem to occupy?'

'What James did not expect, however, was the mind-blowing news that his other-world counterpart had to tell.'

James and his counterpart built up, in their respective homes, a sizeable telephone bill in the days before leaving for University, discussing how their 'worlds' differed, and both decided not to tell anyone about the occurrence, at least for the moment. In fact, both seemed to agree on most issues, but perhaps that was to be expected.

What James did not expect, however, was the mind-blowing news that his other-world counterpart had to tell. In the other dimension it transpired that Germany had won the Second World War. James pieced together what his alter-ego said into a sequence of events leading to this eventuality. Apparently, instead of invading Russia in the infamous Operation Barbarossa (June 22nd 1941), Hitler decided to invade Britain and consolidate his position first. Thus, instead of calling off the Luftwaffe on October 12th 1940, Hitler pursued the Battle of Britain to a German victory. Later, however, when Hitler came to invade Russia, he found his infantry pushed back by massive American forces.

The end result of the Second World War, then, had been a Superpower truce between Germany and much of Europe on the one hand, and America and Russia in an alliance on the other. However, life under the Reich had not been too unpleasant - once Hitler had died of a heart attack soon after the war (type A personality and all that), and more liberal leaders had replaced him. And now Britain was the economic powerhouse of Europe, buying up German companies and causing much economic insecurity. Such had been the determination of the British to once again feel proud, helped by the gradual liberalisation of the Western Block...

James had many questions, as did his identical counterpart, and so it was no surprise that both had surprisingly frequent trips home from University, and always seemed to be on the phone!

So, in conclusion, if you receive a strange telephone call where the line instantly goes dead, bear in mind that it might be an adolescent joker, or else...

John S Gilbody

A Question of Identity

There has been recent debate in the country over the possession of Identity Cards by all its citizens. Some see this as an infringement of liberty, others as a safeguard against fraud and misrepresentation. I'm not sure that they would produce all that is claimed in their favour, although I still have my own Identity Card from wartime days when everyone was expected to carry one.

It has long been expected that nursing, and indeed all staff in the Health Service, should wear an ID badge with their photograph emblazoned on it. This is a mark of awareness about security, but also a way in which patients and clients can know the person they are communicating with. Patients thus have immediate access to the name of their nurse, and can easily pass on complaints or compliments about them. Some staff would prefer only their forename - some surnames can be easily recognised in the telephone directory and result in nuisance calls. The patients' Charter has encouraged patients to 'know' their nurse by the introduction of the 'named nurse'.

Unfortunately this does not always work out well in practice. Despite a nurse introducing him or herself to the patient at the start, this does not destroy the fact that this particular nurse may not be available to deal consistently with the patient. He or she may, after introduction, then be off duty for the remainder of that patient's stay in hospital, or for home visits.

Another aspect which fascinates me about this approach is that, while the nurse is expected to reveal her identity to a patient, there is no compulsion on the part of the patient to reciprocate. I know patients in hospital are 'tagged', but as out-patients or visitors, they can in some circumstances conceal their identity.

Florence Nightingale may, of course, have had a problem of identity in her day. I was listening recently to that excellent Radio 4 programme 'I'm Sorry I Haven't a Clue'. Amongst the most unlikely quotes suggested for the famous, was one from her lips: 'What do we want? Money; When do we want it? Now; Out, out, out!' May seem unlikely, but then Florence, or should she be called Miss Nightingale, wasn't one to kow-tow to the powers in her day?

Another question of identity struck me recently. Just as John Major strode into the rose garden at No 10, who, should appear alongside him but our own Lord McColl. He rapidly retreated as the cameras came into focus. But he had no identity badge. Well, he wasn't in Out-patients that afternoon, so perhaps 'put up' or 'shut up' wasn't anything to do with his identity after all.

But then, appearing on TV is a matter of being recognised and one's identity 'blown', as I discovered. Not that many people seem to recall what you said, it

was simply someone they could identify. Surely that's whatshisname?

But surely we do all need to be known and patients should make staff aware of how they would like to be addressed. By giving the nomination they prefer this would avoid the embarrassment caused when young nurses refer to elderly patients by just their first name. This may not be what the patient likes, and should not be an assumption, as it is, so often.

Many older people would prefer to be known by their surnames, and this wish should not be ignored.

There are few better reasons for wanting to be identified than someone paying attention to us, or caring for us. Retaining secrecy about who we are may only be useful if we have won a lot of money on the National Lottery - but then not many of us are likely to do that!

Denis Cobell

Copy for Gazette

Articles for inclusion in the Gazette should be supplied double spaced, and preferably word-processed or typed. If handwritten, names in particular should be written legibly. If contributions are prepared on a word processor, it would be particularly helpful if a floppy disk containing the article is supplied along with a printed copy. Where possible, text should be saved in ASCII format or Word-perfect 5.1 - or if in any doubt full details about compatibility of different files can be obtained from the Gazette office.

All feature articles should be approximately 1500 to 2500 words in length. Photographs and disks will be returned as soon as possible if requested. Authors are asked to supply a contact phone number in case of any queries that may arise.

Classified ads will be charged at £5 for 35 words and 15p per word thereafter. Changes of address will only be published if requested. There is no charge for this service, nor for annoucements of births, deaths and marriages.

Clement Richard Neve, FRCS London, FACS, FRCS Canada

Richard Neve died on March 12 at his home in Wycliffe, British Columbia, aged 71, from rapidly progressive amyotrophic lateral sclerosis.

Richard came from a medical family, his father being a surgeon in Croydon. He was educated at Epsom and qualified from Guy's in 1945, at the early age of 21. Having completed his house appointments at Guy's he did his National Service in Karachi caring for the families of RAF personnel.

He returned to Guy's in 1948 for further general surgical training prior to the Fellowship which he obtained in 1950. He then went to Bristol where he had an extensive training in orthopaedics, urology and general surgery. He was Surgical Tutor 1951-52 and Senior Registrar there from 1953-1955. In 1955, he, his wife Libby, and their three children emigrated to British Columbia. He had an extensive surgical practice which was almost entirely urological. In 1964 he returned to Bristol, and in 1975 and 1984 to the Institute of Urology, London for further post-graduate training and research. By this time he was a specialist Urologist. He retired in 1992.

I knew Richard when we were students. We qualified the same year and were house surgeons together. We met again in the RAF Hospital, Karachi. After demobilisation our paths again crossed at Guy's working for the Fellowship. Since then we met during his visits to London.

Richard was a wonderful person to be with. He was the eternal optimist and was always cheerful. His enthusiasms and his energy were infectious. Settling in wonderful country in British Columbia his interests in the outdoor life developed. He was an excellent horseman, matched by his wife Libby, and together they bred and trained horses for 3-day eventing. He loved to go to the mountains with the family, camping, hunting or fishing. In later years his passion was gardening.

He suffered his terminal illness with great fortitude and without complaint and will be greatly missed by all his close family, especially Libby and their three children. Our sympathy goes out to them.

C H Kinder

Peter John Hill

The sudden death of Peter Hill from a coronary at the age of 73 came as a great shock to his family and friends. He had recently returned, in excellent health, from his annual skiing vacation in the Alps, and was enjoying skating twice-weekly. He was still treating a few patients in his practice at home.

A long association with Guy's dated from his student days, when he gained the Newland-Pedley Medal and Prize, followed by a Dental House Surgeon appointment. Subsequent National Service in the Army Dental Corps entailed a boring period in Palestine during 'The Troubles' with military personnel confined to camp, but he occupied his time studying for the FDS. After demobilisation he was welcomed back to Guy's as half-time Demonstrator in the recently formed Department of Preventive Dentistry, with a heavy teaching load. As his general practice in the West-End grew, his Guy's appointments reduced to 3 sessions a week, but the Guy's connection was strengthened by marriage in 1951 to Pat (nee Blood) Radiographer in the Dental Department.

A founder member of the British Society of Periodontology (President 1966), he was also a regular attender at the London Dental Study Club (now the Dental Society of London). He will be missed.

R D Emslie

Rugby

Guy's RFC
23rd Annual Reunion Weekend
1-2 April 1995

The reunion was an enjoyable event. As so often, the organiser Terry Gibson was seen desperately trying to sell tickets to impecunious students up to the hours before the dinner. An excellent meal was enjoyed in the Robens Suite. Guests were Mr and Mrs TLT Lewis, an ex captain and president of the club and Mr and Mrs Eric Dann, The head groundsman at HOP. The latter are retiring from their positions in September after 20 years service. The Rugby Clubs presented them with gifts of appreciation the next day.

The dinner was also supposed to be a dance but the band played largely in vain. Captain Beardmore danced with a table. His fiancee seemed not in the least offended. Terry Gibson told a mildly funny story following which the diners took it in turns to relate a joke. This form of entertainment continued until late and whether or not it was a poor substitute for cabaret was beside the point.

The evening was boisterous but reasonably civilised. At least one student running in the marathon the next day attended but many other student members of the Club failed to support the event.

The next day was warm and the grass in front of the clubhouse at HOP was littered with groups enjoying picnics, children and the pleasure of old friends. The captain of the four sides traded players and wheeled and dealed. The first and second present fifteens were under-strength and both sides lost to the past. The President, Stephen Challacombe flew in from America to act as referee to the second fifteen game. Both matches were friendly contested. In the second fifteen game, the past side was losing 12-10 at half time but the

'Awaiting Kick-off'

'A study in concentration during the second fifteen game'

stronger pack eventually took control and forged ahead. The prop Jez Tozer scored three times. It was a similar story in the first fifteen game where the past side included experienced but still active players.

In the bar after tea, Stephen Challacombe thanked Mr and Mrs Dann for their wonderful service to the Rugby Club and to sport in general at HOP. They were presented with a set of crystal glassware.

The fine weather attracted a relatively large number of people and it was good to see so many families. It was a memorable weekend and one which ensured that the reunion will continue into what is in other respects an uncertain future.

Players - G. Tsolakides, D. Evans, L. Hostert, M. Ansell, A. Bates, A. Jeffries, M. Sharp, B. Challacombe, J. Davies, V. Gradillas, U. Ekeona, M. Jenkins, R. Breeze, S. Roiser, M. Lewis, J. Morgan, J. Burt, R. Dixon, D. Baladason, C. Beardmore, E. Rose, W. Llewellyn, J. Boothroyd, R. Docker, N. Davies, P. Gush, A. Jones, G. Bevan, A. Hall, D. Godfrey, M. Lewis, M. Lewis, B. Eddy, K. Lewis, S. Pryke, Christian, R. Dales, M. Martin, K. McKnight, M. Blundell, J. Coombes, G. Barwell, A. Jones, S. Redding, C. Howell, T. Gibson, J. Tozer, K. Conchie, N. Dennett, J. Conchie, R. Bowskill, D. Gibson, J. Brazier, C. Croft, C. Barry, P. Chew D. Vickery, A. Watts, H. Jones, M. Clewley, P. Davis.

Guy's Hospital 2nd XV vs St Thomas' Hospital 2nd XV

In one of the few matches in the Cup since the formation of UMDS, both of the sides were drawn against each other, following St Thomas' defeat of Royal Free two weeks before. With Guy's playing into the wind in the first half they soon found themselves pinned deep in their own half due to some fine kicking from the St Thomas' flyhalf Gradillas. This constant pressure on the Guy's line was soon turned into points with Prodip Das scoring from no 8 with two pushover tries. Guy's were unable to answer until the last minutes of the half when a fire break by Murphy put the winger Arastu over in the corner. The teams turned round with St Thomas' leading 10-5, all tries having been unconverted. With St Thomas' now playing into the wind and Gradillas lacking a few yards in pace, Guy's now began to take control. In a seemingly innocuous move Arastu kicked on after receiving a good ball and beat the cover to the touchdown to level the score at 10-10.

Guy's were then able to continue the pressure and score swift handling put Gibbins over unchallenged on the left wing. St Thomas' then threw caution to the wind in trying to run the ball from deep in their own half and conceded two penalties, both of which Gush, the

Guy's Captain, succeeded in converting.

The final score was 21-10 with Guy's earning a hard fought victory in what was probably their toughest game in their successful cup campaign.

Team:
Don Baladasun
Finbar O'Sullivan
Indy Schofield
Mark Ansell
Graham Lawton
Roy Dunningham
Marcus Sharp
John Murphy
Ronan Brown
Ben Stochnam
Pat Gush
Nick Gibbins
Matt Arastu
Matt Rose

Football

Second XI End of Season Report

The old cliche 'So near yet so far' really sums up the fortunes of the second XI football team. In the end no silverware was brought home. Instead, the promise of greater feats next season was all that we managed to salvage.

The season started off well enough with wins for all three of the club's teams in the various concurrent competitions. Most impressive of the early victory flutter was the progression made by the second XI into the quarter-final stages of the UAU competition. Alas, here ended the dream of wining the UAU. On the day of the quarter-final clincher, the fear of a crushing embarrassment resulted in a sudden abandonment by the regular crew and saw the team being made up of an ad-hoc collection of club players, who were subject to ninety minutes of hell resulting in a devastating defeat at the hands of Sheffield University 2nd XI. This defeat along with the previous week's incumberance in the Hospitals' Cup, left the second XI focussed on the last remanining piece of silverware, the UL Cup.

The second half of the season seriously put to question the fitness and committment of the players, as the good old British weather took its toll and forced multiple cancellations. Indeed the first match was played during the end of February, approximately six or seven weeks after the recess. However, this minor hinderence did not dismay the determined lads, as they pulled out a series of results which were on par with the early season successes. Indeed, this skillful form won the day against fierce, fiesty and dirty opponents from LSE in the quarter-final of the UL cup (though I'm sure some would argue that the second XI had additional help!). This is when I realised that being a match referee should be listed as one of the world's most dangerous occupations!

Following the win over LSE, came the season's most dramatic moment. Imagine if you can the following: the team is all hyped-up to play the semi-final against Kings' IV, a side they had previously beaten in the league. The fixture was set for an early kick-off on a sunday afternoon, the only problem was that everybody knew about it apart from the second XI. Initial blame fell at the feet of our disgraced captain (*he was sent off for unsportsman-like conduct:-* in simple terms he throttled a bloke!), though it would be fair to say that he didn't really lose any hair over it! Although the fixture was rearranged, the eventual culprit, a certain young female at ULU continued to haunt the club with further administrative plops (resulting in the first XI being relegated!). In the match itself, UMDS were outplayed by a team obviously made up of 'ringers'.

Thus, the season came to a bitter end but they say that every cloud has its silver lining, and I suppose for us it was probably the fact that we did not get relegated from our league.

The season was concluded by the summer AGM, at which we resolved that the club had great prospect for the coming season.

Squad: Argi, Bolts, Wisey, Neil, Andy H, Riki, The Wall, Growler, Gerber(c), Vatche, Ranju, Eldo, Imie, Ollie, Andy L

Rikin Trivedi

'Anyone for Hockey?'

United Medical & Dental Schools of Guy's & St Thomas' Hospitals
Medicine
Final Year Pass List 1995

Ahmad, Miss F
Austin, Mrs R J*
Ayaru, L*
Bahl, Miss R
Bailey, S T
Bates, A T
Binns, Miss H E*
Blunden, M J
Booth, A D
Bowles, K M*
Bradley, P G
Breeze, R F
Brink, T D
Brown, Miss S K
Buchanan, J A G
Bugg, Miss D M
Burt, Miss JE*J
Burton, P B J
Butterworth, Miss S E
Cackett, P D
Champion, Miss L M V
Chan, S C E*
Chatterjee, S
Cocker, D P*
Constable, S A*
Dales, R D
Das, Miss A
Davis, Miss C K N
Dayer, M J*
Deeley, P Q
Desai, V
Deverill, J E
Don, Miss C M D
Edwards, A R
Elamin, A F M
Evans, Miss S E*
Everett, Miss L A*
Fatheazam, Miss A C
Firoozi, S*
Fisher, C J H
Foley, Miss L M
Forgie, Miss B M
Frost, Miss L D
Fry, Miss A
Gamble, D St J
Gangola, M
Garrood, T J
Gilbert, M T
Gillett, D
Ginks, Miss R L*
Goodall, Miss V J
Goodyear, P D
Gosall, G S
Graham, Miss J
Green, Miss S E
Gujral, M S
Guinness, R M
Gunny, Miss S R
Gunstone, A E B*
Hall, Miss C J
Haq, S M*
Harris, Miss C B
Hepher, Miss R J
Higgs, R D
Hodgson, T A*
Hogben, Miss C E
Holmes, S B*
Hordern, Miss S V M
Howells, M
Hu, Miss J C C
Hubbard, Miss V G*
Huda, Miss T F J*
Hughes, E H*
Hussain, Z
Iacovou, M A
Ivil, K D
Jaggi, Miss S K
Jain, A
Jain, P C
Jain, Miss R
Jain, Miss S
Jani, Miss B L
Johnson, Miss E M
Jones, J M
Joynes, Miss E V o
Kalairajah, Y
Kansagra, K B
Khan, M F
Kitching, Miss M D*
Kushwaha, R S
Lear, Miss C
Lengyel, A J*
Lewis, K E*
Lewis, M C*
Lightfoot, R P
Lindsay, Miss A S
Lowe, Miss R M*
McGinn, Miss O M
McKintosh, J E
Madon, K S*
Mahon, B S
Mai, H T
Mallik, Miss P
Marino, P
Mathias, Miss M C
Mehta, H*
Mehta, J S
Mehta, S S
Michaelides, Miss S
Morris, S L
Murray, Miss A M*
Muthucumarana, Miss D J
Nair, S*
Nanavati, N J
Naqvi, Miss S B N F*
Nemati, Miss P
Nevin, Miss K J
Nickol, Miss A H
Noursadeghi, M*
Osborn, M R*
Palmer, R A
Parker, Miss J R
Parnia, S
Patel, Miss A C
Patel, Miss M
Patel, P S
Patel, Miss T

Patel, V A
Peace, Miss K A L*
Phillip, R D
Philpott, Miss AL
Piper, E J
Planche, Miss K L*
Power, Miss D A*
Predescu, Miss O S
Probert, R M
Purchase, Miss R B
Puri, Miss B
Purslow, Miss E C
Rahim, F O
Rahman, Miss S S
Ramamoorthy, S
Reece-Jones, Miss H M
Ritchie, J F S
Roberts, Miss N J
Russell, S G W*
Sabin, M A*
Sahni, Miss A R
Saich, Miss R C*
Sapuay, Miss B C
Sattar, Miss Y
Sawhney, R
Sefton, J D*
Self, R E
Selvadurai, Miss E D
Shah, J
Sharma, R*
Sheikh, M A*
Sherman, S J
Shin, G Y
Singarayer, Miss J
Singh, Miss A*
Singh, Miss N K
Singh, S
Singh, S K
Spicer, J F
Stannard, Miss K J D
Styles, Miss S J
Tharumagnanam, Miss N
Thompson, Miss C L H
Thwaites, G E*
Till, J o
Tutton, M G
Vaidya, Miss N I M*
Varma, R*
Waheed, U
Wahie, S
Walsh, Miss C Z
Ward, Miss C L
Waterman, Miss J K
Webber, Miss R H
Willier, Miss V
Wilson, Miss G M H
Yee, M S
Yim, Miss L-J J
Zaidi, S J

*= *Studentsawarded distinction*

The following students qualified the BDS degree in June 1995 and are all life members of the United Clubs.

Amin,Prashant
Auplish,Gita
Baghaie-Naini,Farhad
Bandlish,Rajiv Kumar
Bisase,Brian Kupuliano Simon
Carey,Christine Ruth
Creedon,Martin Ignatius Mary
Crudgington,Jennifer Ann
Dhatt,Harrinder Singh
Dholakia, Pratish Harishchandra
El-Sayegh,Lama
Faulks,Denise Fisher
Fulthorpe,Jennifer Anne
Goodwin,Sharon Ruth
Grainger,Frances Ann
Hill,Joanne Nicola
Hindle,Samantha Jane
Hoare,Johnathan James
Hobkirk,Andrew James
Howsam,Gary David
Invest,James Clive Frederick
Karia,Kripa Sharmilla
Kaviani,Kamyar
Laidler,Tara Louise
Lubbock,Monica Josette
Lucy,Virginia Alice
Macmillan,Neil John
Maos,Dimitrios
Matin,Katayon
Moller,Martin Kevin
Nguyen,Anh Nghi
Nikkhah,Cyrus
Nisar,Mohammed Asam
Padhani,Salima Pyarally
Pambakian,Zvart
Patel,Hetal Bhupendra
Patel,Shanon Shashi
Patel, Dipesh Kumar Hariprasad
Peart,Victor Hale
Perera, Uswatte Liyanage Niranthajoseph
Polycarpou,Nectaria
Prinja,Navita
Quinta,Maria Margaret
Rahman,Sahrin
Rigby,Anneliese Claire
Roberts,Michelle Anne
Shah,Rishma Asvinlal
Shah, Pritesh Mansukhlal Meghji
Sharma,Malti Kumari
Shaw,Tracey-Jane Scott
Shenouda,Mary
Sherwin,Charles Michael
Shori,Sangita
Siddiqui,Aisha
Spilker, Nicholas Masakatsu Christopher
Stacey,Adam Craig
Topping,Jacqueline Anne
Travess,Helen Claire
Tsolakides,George
Tyler,Sara Louise Adelaide
Udani,Tejas Nalin Kumar
Vamadevan,Vamini
Vijayadeva,Sheila
Wheatley, Annabel Catriona Varley
Woo,Karen Yan-Yan
Yousef,Seema Raza

The following students qualified the BDS degree under the old curriculum in June 1995 and are all life members of the United Clubs.

Raichura,Svinita Rina Bhavna
Shabbir,Aliah
Wallder,Paul Anthony

Death

Mackenzie, Clive Angus Garrick, died 24 June 1995 aged 62. Born Twickenham 3 November 1932. Educated Latimer School and Guy's Hospital (MBBS, MRCS, LRCP 1957). General Practioner in Woking and Oxshott, Surrey (1960-77) and Horsham, West Sussex (1989-93), with 12 years in the Middle East (1977-89). He is survived by his wife, Christine, and a son, Simon, and daughter, Claire (who trained as a nurse and then as a physiotherapist at Guy's) from his first marriage.

Guy's Dental Hospital and Centenary Fund

Donations of £75 have been received in memory of Colonel FT Wilkinson, who qualified from Guy's Dental School in 1927 and died on 28 May 1995.

Fison Memorial Lecture

The Fison Memorial Lecture will be given by Dr RK Knight, entitled 'Addison, Keats and London Bridge' in the Tower Lecture Theatre, floor 30, Guy's Tower, on Tuesday 31 October 1995 at 5.30 pm.

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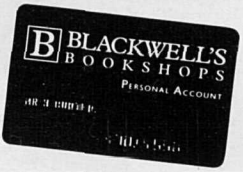

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Guy's Gazette

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Passim

Let me start by introducing myself. My name is Rikin Trivedi and it is with a great deal of honour that I take up the editor's seat at the gazette. We have a great history here at the Guy's gazette, in that we are the oldest hospital journal in the world and it is my intention to maintain the success and tradition that we have previously enjoyed.

We have gone through what has been a harrowing period in our past and we are proud to say that we have come through with great strength. Although the political climate may have simmered, the battle is not yet won and it would be to our peril to disregard the ongoing work of the 'Save Guy's Campaign' and all of the other loyal supporters that have fought defiantly for our cause. The recent appointment of a new Health Secretary has brought with it a glimmer of hope for the NHS in London and the future may perhaps be more negotiable than it once was.

The changing pattern of healthcare is being equally matched by changes in medical education. The United Medical and Dental Schools are leading the way with a displacement from traditional teaching methods to a core curriculum with a more 'vertical', patient based foundation. This can only be good, since after all if it were not for patients we would not need doctors.

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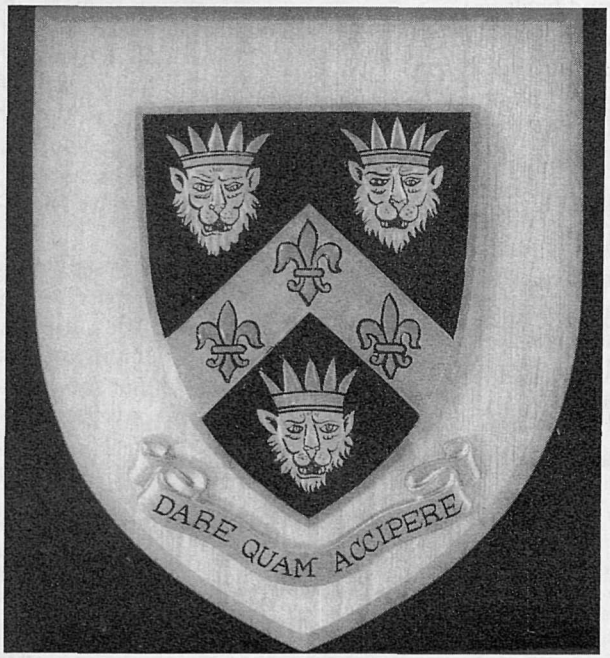

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Please make cheques payable to Guy's Hospital Gazette

Office hours: Monday to Friday 1-5 pm. Personal callers welcome.

NO PARKING

Dear Sir,

I have just recently returned back to Guy's to discover the abominable changes that have occurred. I am refering of course to the ridiculous situation regarding parking within the hospital grounds during off-peak times. I find it absurd that a charge should be made for parking at these times. I hazard to think what effect this has had on the staff working the twilight and night shifts, especially in light of the importance of safety. Have the Trust Board got that large a deficit in their annual budget that they have to stoop to such actions?

Yours faithfully,

Alamgir Kabir

ALTERNATIVE SCIENCE

Dear Sir,

Could I bring your attention to a very interesting piece of mail that I recently received. It is, I believe, a very popular scientific journal in South East Asia, called 'Acta Medica Kinki University', printed by the Kinki University Medical Association.

I am told that we are suffering in this country, from fewer and fewer applicants for degrees in scientific subjects. Could this be because our institutions lack the same attraction that the overseas universities seem to have?

Yours faithfully,

S M Pitt

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts please write to the editor.

You are reminded that it is at the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will however do our best to let you have a say.

Dental A & E Gets A Polish

The Accident and Emergency department of the Guy's Dental Hospital has received a £200,000 face-lift. During the refitting, the department remained fully operational. The refurbished new department is now home to new state of the art dental equipment.The new look brings together a modernisation in both the Dental and Medical casualty departments.

BOLAND HOUSE

Boland House has undergone a number of changes in the last 10 years, in order to make the best use of facilities to accommodate the ever changing needs of students. Much of this industry has focused primarily on the first floor, which houses amongst other things the Conybeare Club (though not truly a student dwelling). Work has begun once again on the first floor of Boland House, in a strategy which proposes radical changes to the use and layout of currently available space.

Postgraduate Course

Guy's and St Thomas' Hospitals Head & Neck Oncology Service is offering a one-day postgraduate course on 'The practical aspects of diagnosis and management of head and neck lumps and assorted cancers' on Friday 20th October 1995. The course is aimed at the recognition of oral disease for general practitioners. The programme will include: aetiology of head and neck cancer, differential diagnosis of salivary gland lumps, diagnosis of oral and laryngeal cancer, oral disease - the link to systemic disorders, management of oral cancer, the thyroid & lumps in the neck, role of RT in head and neck cancer, role of primary services: the patient's perspective and palliative care. PGEA Accredited (6 hours: 5D + 1H), Course fee £50.00 (including lunch, tea and coffee). For full details and an application form contact Professor McGurk's secretary, Department of Oral & Maxillofacial Surgery, Floor 24, Guy's Hospital, London SE1 9RT. Tele: 0171 955 4342, Fax: 0171 955 4165.

Southwark Festival

The Southwark Festival is an annual event. This year it is going to be held between the 9-20 October and will feature:

- Evening concerts and lunch time recitals in Southwark Cathedral
- Lunch time and rush hour concerts in Guy's Hospital Chapel
- A Brenda Lucas Ogdon piano recital in Guy's Hospital Chapel
- Concert in aid of the Friends of Guy's Hospital to be given by Sagittarins featuring Monica Hugget on violin
- Concerts will also feature: Bournemouth Sinfonietta, Royal Philharmonic Orchestra, London Adventist Chorale
- Exhibitions of paintings at: Price Waterhouse, Hop Exchange, Financial Times Building, Pizza Express
- Fun Day in Borough Market 11.30 - late on 12th October. This day is in aid of Time and Talents and Manna Centre, both of which are Registered Charities,and will feature bands such as: Bobby Lamb and Trinity, Goose Swordfish, Daddy Long-Legs
- Pavement Artists' competition in Hay's Galleria

FOR MORE INFORMATION CALL THE BOX OFFICE ON 01395 223400

Health Visit

Stephen Dorrell, Secretary of State for Health, on his recent visit to a London Hospital made assurances to Londoners that he would do all that he could to ensure that nothing would happen to the NHS in London unless it lead to an improvement on what there is now. He went on to say '..I am deeply committed to the NHS.' It is hoped that his new appointment will be more prosperous for Guy's than was his predecessor's.

In a separate report, being introduced by the Department of Health, Mr. Dorell has outlined proposals for a novel scheme to filter out poorly performing staff. His new ideas are aimed at encouraging doctors to report their peers if they feel that their performance is below par, by establishing an anonymous phone line especially for this purpose. The scheme has been backed by both the British Medical Association and the General Medical Council,and if it takes off it will seriously put to question the autonomy that exists within the medical profession.

Guy's Hospital — 250 years

Have you ever wanted to know more about the history of Guy's? What was student life like in the nineteenth century medical school? What happened in the Residents' Plays of the forties and fifties? How about nursing, midwifery, the Wills Library? Or the early days of X-rays?

This 240 page, illustrated paperback gives a history of the achievements in every field of Guy's life for the past 250 years, and is available for only £2.95, including postage and packing, from the *Gazette office. The book makes an ideal gift, and only a limited* number is available.

Please send cheques or postal orders, made payable to Guy's Gazette, to Guy's Hospital — 250 Years, Guy's Gazette, Boland House, London SE1 9RT.

An Interview with the Principal

First man of UMDS

Professor Chantler is a consultant in Paediatrics and Paediatric Nephrology at Guy's campus and, as most know, is also the Principal of UMDS. He agreed to share his views concerning some of the more hotly debated issues concerning the future of Guy's and St Thomas' hospitals with respect to the future of the curriculum, the merger with King's College and the Government's health reforms.

Professor Chantler began his medical studies at St Catherine's College, Cambridge in 1957 and then moved to Guy's in 1960 to complete his clinical studies. He then began his post-graduate training at Guy's, including a House Physician post on a paediatric firm, and then moved to Greenwich and later to the London Chest Hospital before returning to Guy's to work for the MRC external unit conducting research into the measurement of glomerular filtration rate. He passed his membership exams in adult medicine and then returned to paediatrics and worked at the Hammersmith Hospital, Great Ormond Street, and then the Queen Elizabeth Hospital. He then returned to work for the MRC before he was appointed a Senior Registrar. He then moved to San Francisco as a travelling research fellow, ultimately returning to Guy's as a consultant in 1972.

Why did you decide to become a Paediatrician ?

I enjoyed the paediatric firm at Guy's more than any other that I had done until then and the paediatricians seemed to be the most approachable of all the staff that I had met. Of course now all consultants are equally approachable!

What is your most memorable experience of medical school and/or your career so far ?

I think it was probably the foundation of a department of paediatric nephrology at Guy's, and I have gained immense satisfaction from seeing it develop and strengthening its clinical work. It was also important to devise a multi-disciplinary approach to the management of the unit as I don't see how efficient care can be provided unless there is a team of people from different professional backgrounds actually working together. I see the service that we provide to children here, and particularly those in the renal unit as my greatest thrill providing as it does a children's hospital within a hospital. On the whole, childrens' services are not well provided in large hospitals and it seems to be the opinion that children should make do with adult facilities. We were determined that this would not happen and we campaigned for a specialised children's casualty department as it provides a window out to the local population and if Guy's or St Thomas' are about anything, they ought to be about caring for the local population.

Can you tell us how you ascended to the role of principal ?

Well, I'm not sure that its an 'ascension' but there are certain jobs that you feel you would like to do if they were offered to you and as you get older, your job changes. I'd always wanted to be involved with the medical school as I became older as it seemed the best job that one could possibly have. The main reason that Guy's and St Thomas' exist as teaching hospitals is due to the medical and dental schools. If it weren't for the students, then there would be two very different hospitals and as I keep saying, students are the second most important people in the hospital after the patients. Therefore it appealed to me to become more involved with the undergraduate teaching. I still enjoy being a Doctor but I no longer feel that I can contribute to research as I used to and so I have now concentrated on my teaching, clinical, and administrative work.

There are growing concerns regarding medical education in the school. Do you not feel that the quality of teaching will be compromised at UMDS with the majority of clinical services concentrated on the one site?

I don't see that there should be any difficulty. I think that all the changes will show an incremental improvement and the needs of post-graduate students and researchers must also be taken into account. However, that being said, I am

primarily concerned with the needs of the undergraduates and the first thing is to develop the curriculum at a sensible pace. We have now started to put in place a new style course whereby pre-clinical and clinical disciplines are being vertically integrated. We feel that this will make understanding medicine easier. Even now, we are not even half way through developing the new curriculum and we still have to define those areas that require core understanding and teach them in a fashion that means they are thoroughly understood. In addition to this, we also want to give students the opportunity to study specific study areas that interest them whilst developing their skills. This is one of the reasons why I am very much in favour of the intercalated BSc not just in subjects related to biomedical sciences, but also in subjects such as history of medicine, ethics and law for example and I feel that these opportunities will be enhanced by the merger with a multi-faculty college, ie King's. I also feel that it is essential to use more problem-solving throughout the course as a means of acquiring understanding because clinical medicine is based around problem solving.

Therefore we want to develop the curriculum as defining 'core' knowledge, ensuring that it is properly understood, using problem-solving exercises as a tool for learning, providing specific areas for personal interest and finally to ensure that this occurs in an amicable environment both between the students themselves and also with the lecturers so that students can feel comfortable with discussing medicine and develop friendships with their teachers.

Is it true that the majority of clinical teaching will move over to St. Thomas'?

The majority of clinical specialties will move but not necessarily the teaching. Although most of the in-patient services will move over to St. Thomas', a huge out-patients service will remain at Guy's and it is in out-patients that teaching will actually be concentrated. This is particularly so with increasing medical technology as the duration of a patient's stay in hospital is rapidly falling and so there isn't the time for the students to clerk on the wards and receive teaching quite as there used to be.

We try to develop a method of teaching which is now called reflective practice where the teacher's role is more as a coach and the student is encouraged to think about what they do which is then discussed with the teacher. Clinical teaching is mainly in the first two years of clinical practice

with the last year being spent refining these skills and thereby reducing the stress of the finals. That being said, there will be some in-patient services at Guy's and also with the merger of UMDS and KCL there will be more students and also the availability of the King's campus. Concerning how we will manage all the medical students, I think that we will probably divide the students into 'houses', each with a base predominantly at Guy's/St Thomas' or at King's.

As far as the merger with King's is concerned, it will cost a great deal of money of which the Government, UMDS and King's are all contributing. It will involve knocking down Hunt's House and completely rebuilding it, making use of Shepherd's House and the Nurses Home for laboratories and the development of a clinical skills laboratory for students to develop their clinical skills. I also want to educate nurses and doctors side by side as much as possible, particularly concerning ethics and patient communication as these two areas are very similar for both professions.

Do you feel that it is in the school's best interests to merge with King's and if so, what to you feel the school will gain from the alliance ?

The benefits are fourfold. Firstly, we will be part of a multi-faculty school that will enable us to share social opportunities with students from other faculties. After all, there is more to life than medicine and it is useful to have friends with differing perspectives on life. Secondly, we will greatly strengthen our science base by uniting the teaching of basic medical sciences at Guy's. This will also benefit our research. Thirdly, we will have new modern buildings in which to work which will undoubtedly be of benefit to us. However due to sheer financial cost this would not be possible without a merger. Fourthly, the presence of all the pre-clinical faculties on one site with the clinical sites nearby will surely enable us to fulfil our obligations to improve the curriculum and therefore student teaching, particularly with reference to improving pre-clinical and clinical integration.

One of the major concerns of the student body is that the merger will result in a loss of our identity. Do you think that the students are warranted in having such worries ?

We have been devising various constitutional and administrative methods to ensure that the needs of the medical and dental schools from both sites are maintained. At present we are making excellent progress and in fact, I wouldn't

allow anything to overcome the interests of the students. Also, the clubs unions will most likely be maintained separate from the main college and I have discussed at great length with the clubs officials to ensure that they are satisfied with our progress. Incidentally, it is possible that the medical and dental schools will be separated since they will be so large.

We are also discussing the title of the new college. I suggested that it should remain UMDS but King's administrators were not so keen. At present, the working title is Guy's, King's, and St Thomas' Hospitals' school of medicine and dentistry until somebody can come up with a better solution but I believe that the names of Guy's and St Thomas' should remain in the title.

It is not implausible to think that, should there be a change in government, there may be a U-turn in the decisions made concerning the merger. How do you think that this will affect the hospitals and in light of this, should we be so ready to commit to the merger?

I think that it is highly unlikely that any change in government will alter the general change that is occurring in London's healthcare.

Many people believe that UMDS should have argued more heartedly for a two-site option. Should this have been done ?

In fact we did argue very strongly for a two site option since the better the facilities on both sites, the better the opportunities for teaching.

So, don't you think that the single site option will actually be detrimental to our teaching ?

It is not a single site option because the main focus will be on out-patient teaching, and I feel that the benefits will outweigh the disadvantages. I think that if there was any danger of damage to teaching, then the school would object most strongly to the proposals.

Principal, you have captained the UMDS vessel through the stormy weather of the past couple of years. Do you feel that there may be future repercussions following the damage to our two mother ships?

Both Guy's and St Thomas' are immensely strong institutions and have been around for a very long time and I feel that they will emerge from this period very strongly. In fact, the hardest period is probably at present and the trust is

doing all it can to ensure that the day to day running of the colleges are unaffected. The only problem I can see is the unwillingness of outside organisations to invest in research because of uncertainty and so what matters is to physically start the changes since as soon as people see the work actually progressing, and research is finally moved to Philip Harris House, the problem should be rectified.

When I took the job on, I had no idea that the Tomlinson Report would occur and cause so many problems, but I feel that we have come through this period very well.

Do you agree with the findings of the Tomlinson Report ?

I do actually approve of the constitutional merger of teaching hospitals as there were too many providing specialist services. I also approve of the merger of the Medical and Dental Schools as long as it is done properly.

Hypothetically, if you were Minister of Health, what would you have done differently ?

Unfortunately I cannot answer that question as I have a seat on the NHS Policy Board.

Would you like to see medicine becoming a post-graduate course as it is in the US ?

Definitely not. However, I do approve of students taking a year off before coming to medical school and I feel that it would be a lot easier if people actually applied following their A-level results. I would also like to see more graduate students since different people mature at different ages.

Is it likely that pending the merger with King's, a principal will be appointed from UMDS ?

A Dean who will be a Vice-Principal of King's College will remain for the merged medical and dental schools but there will be a separate post for the new college as a whole.

Can I return to your student days, concerning the rumours associating you with a fire extinguisher and a skylight in the Gordon Museum...

Ha! I believe that this rumour was started by a previous firm of mine after I told them about an incident whilst I was a houseman at Guy's. On the site where the tower now stands, there used to be a building known as the college. When it was closed down, on the last night before it was to be demolished we all decided to have a party. Somebody dropped a beer barrel through the skylight of what was the equivalent of the spit and someone else set off a firework which managed to enter London Bridge Station, alight, causing a certain amount of trouble. I didn't actually see the incident and only heard about it the next morning. However, I do remember that the Superintendent of the Hospital was not amused.

On that note then Principal, do you think that the medical students of today are more or less erratic than when you were a student ?

I don't have any problems with people enjoying themselves as long as nobody is forced to do anything, nobody is in danger, the reputation of the school or hospital does not come into question, and also that all breakages are paid for.

Principal, if I may, can I stick my neck out here and ask you if you've ever been 'ginned'?

There was no such thing to my knowledge as 'ginning' when I was a student. Instead, we used to drink yards of ale. I was never forced to drink the yard but I do recall doing so.

Finally Principal, do you have any words of wisdom for the students ?

I would say to them have fun, work hard and play hard. Try to understand yourself and your fellow human beings.

Paul Hayden

TO MARK THE OCCASION OF THE LAST GUY'S TRAINED NURSE IN 1996
we have commissioned a

ROYAL WORCESTER PORCELAIN FIGURINE

of a

1960's GUY'S STAFF NURSE

in a limited edition of 750

She will be a standing figure 9" high, dressed in the '60's uniform of mauve and white pin striped dress with mauve collar and white apron. She will wear cap and strings, a Guy's Nurses' League badge and buckleless black belt, grey stockings and flat black shoes, and a short black cape with its scarlet lining. She will stand on a decorated square plinth approximately 2" square.

The figure will have a special limited edition base stamp on the underside of the plinth, and will be individually numbered. Each figure will be supplied with an embossed certificate of authenticity displaying the Guy's crest as well as that of Royal Worcester and the signature of their Chairman. It will come wrapped in bubble packaging in a Royal Worcester box and cardboard mailer. Every figure will be minutely checked before packing, and insured until it reaches the purchaser. The first figures should be ready early in 1996.

The name ROYAL WORCESTER speaks for itself; the exquisite detail and beautiful workmanship is world renowned. The figure is based on the series of London Nursing Sisters, which were produced by this company in limited editions in the 1960's with enormous success. Each figure will be aerographed and hand painted by the same few artists to be as alike as possible, but of course no two will be identical. As a limited edition, produced at this momentous time in the history of Guy's Hospital, these beautiful figurines can only rise in value, and will be a wonderful investment, gift, or heirloom. Our initial announcement was received with tremendous enthusiasm by members of the Nurses' League at their AGM in May this year and we have already received orders for 20% of the edition. With this first advertisement we are expecting a huge demand now from Guy's nurses, medical and dental graduates, physiotherapists and radiographers - members of this unique world-wide family that has been GUY'S.

COST: £225 INCLUDING VAT (17½%) AND P&P within the U.K.
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Please cut off and send the order form below together with your deposit of £100 as soon as possible to avoid disappointment.

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SAVING GUY'S

Address to the Guy's Nurses' League May 9th 1995

There was nothing fair about the threat to Guy's and trying to look for mistakes that we have made and ways in which we could have avoided the attack on our Hospital are futile. The Government did have justifiable grounds for a reasonable reduction of hospitals and hospital beds in central London. The population had moved out. Peripheral London and provincial hospitals had increased in size and stature. Their doctors and nurses had brought to them the traditions and standards of their own teaching hospitals. Indeed the sons and daughters of Guy's have built up some of those hospitals and taken on the work which their parent hospital once did.

If things go wrong it is helpful to have someone to blame. If we blame anyone we should blame the Charing Cross Railway Company for building an extension London Bridge Railway station in 1862 which displaced St Thomas'. At first they moved to Newington but in 1868, they moved St Thomas' to their site opposite the Houses of Parliament which has proved to be an unassailable political fortress. If only the two hospitals had remained on the London Bridge campus. The United Borough Hospitals could have created UMDS over a hundred years ago. Many of us would have used up our energies rather differently in 1994 and 1995.

> ***'The Government did have justifiable grounds for a reasonable reduction of hospitals and hospital beds in central London.'***

Turning on more than a century in our history, Guy's was launched as the Flagship Trust into the calm waters of the NHS market place in 1991. The shrewder pilots warned us of storms brewing and the difficulties of fighting for open sea while we were surrounded by King's, Lewisham and St Thomas'. We worked harder, we built up world-class clinical units in renal medicine, in breast cancer, in paediatric specialties, we contributed the majority share not just of clinical professors but of clinical research to UMDS. We ignored the massive and, then, unjustified enlargement of the St Thomas' A & E depart-

ment. When Trusts began to advertise their services, we turned a blind eye to the anti-Guy's publicity put about by rival nearby Trusts. We failed to protest when our successful alliance with Lewisham was broken up. We even accepted a partnership with our sister hospital in UMDS without a murmur. That break-up, that new partnership were the beginning of the end for Guy's. Events then moved quickly with the appointment of the ex-St Thomas' Chief Executive, and soon after that of St Thomas' personnel to the other key executive posts. The new Public Relations Officer, fresh from St Thomas', found herself in the presumably uncomfortable position of promoting the virtues of the Hospital which until recently had been part of a rival 'business'.

'The Department of Health rejected the option and in considerable haste and secrecy asked the Trust to model several different options...'

With an Executive thus drawn from the St Thomas' campus, the combined hospitals were charged to develop a rationalised configuration. The Trust put forward an Option in which St Thomas' was the acute hospital with the A & E department and Guy's was a specialist hospital. This option was not popular at the time with the Guy's consultants. There were difficulties over the configuration of specialties. The Department of Health rejected the Option and in considerable haste and secrecy asked the Trust to model several different options, eventually emerging with an option which moved the whole inpatient service from Guy's to St Thomas, leaving Guy's as an Ambulatory Care Centre and Medical School. This was the Option which the Secretary of State put forward as her decision on the fateful Friday, February 10th 1994, which must go down as the blackest day in the history of Guy's.

'February 10th 1994...must go down as the blackest day in the history of Guy's.'

The Save Guy's Campaign sprang up overnight under the chairmanship of Simon Hughes, Liberal Democrat MP for Bermondsey, and co-chaired by Roger Sims, Conservative MP for Chiselhurst, and by Tessa Jowell Labour MP for Dulwich. The coordinating committee has been meeting weekly in the basement of a nearby restaurant. The campaigners have worked incredibly

hard. The campaigners included senior members of your own league, Margaret Roberts from the Friends of Guy's, and Alec Schwartz from the Guy's Kidney Patients Association, aided by a host of volunteers, including a Mum's Army of consultants' wives and hospital friends. Old friends came back to help, Donald Bompas, Hugh Saxton, Max Rendall, George Scott. They made the Campaign front page news and, with the help of Jo Revill, filled the Evening Standard, raising the publicity profile of the Campaign. They collected over a million signatures on a petition praying parliament not to close Guy's. They pursued a campaign to bring home to decision makers that Guy's is still needed.

The fund raising was very successful and many of you in this room worked incredibly hard and I would like to thank you now. The campaign has already raised a quarter of a million pounds under the enthusiastic guidance of the Treasurer, Mr. Michael Gleeson. It was also enormously heartening to realise the support we have all over the country and many of the events were tremendous fun. The highlight to my mind was the Concert in Southwark Cathedral which was the brainchild of Gay Ogg, wife of Dr Chisholm Ogg, renal physician. The Vice Provost of the cathedral opened the Concert and made clear that the clergy were on our side, even if the Government is not. The Linden Wind Orchestra played. Bob Knight our senior physician gave a marvellous address from the nave but was upstaged by no less than Thomas Guy himself. The Actor Martyn Read portrayed a humorously resurrected Thomas Guy, pondering ruefully upon what the Secretary of State was proposing for his endowment. With the help of Raymond Butcher from 'A Piece of Cake' (which has become if not the heart at least the stomach of Guy's), who generously provided the catering, we raised nearly £10,000 in that evening alone. The other moving fund-raising event was a marvellous pantomime entitled 'Who's Afraid of Virginia Wolf' in which Betsy Morley gave a not-to-be-forgotten rendition of the Little Red Hiding Hood story in which the

'The Southwark Community Health Council filed an application to sue the Secretary of State on the ground that she had proceeded unlawfully in making a decision without consultation...it was our first battle won.'

chaplain Neville Smith showed that the Church's gain was the West End's loss with a portrayal of a buxom widow Twankey. We had a Ball at the Hilton, a Virtual Reality evening in the Basement of Hamley's, and a Charity Football match at Millwall. We had street collections, we sent out appeals to the consultant staff and to the alumni. Gradually the money came. It came in pennies, it came in pounds and it came in great donations. Guy's can be proud of the depth and breadth of its support and is very grateful for everyone's generosity.

During the first months of the Campaign we instructed solicitors and then Counsel to challenge the Secretary of State's February 10th decision to close our A & E department and move our in-patients services to St Thomas'. Within 24 hours she responded that she had not made a decision but only declared a 'strategic direction' and that 'no decision' would be made until consultation had taken place. It was our first battle won.

At the same time we realised that we would need to offer some other plan than the closure of Guy's which was being worked up by our own Trust on the Secretary of State's instructions. We instructed KPMG, a well known firm of management consultants to develop alternative two site options, which rationalised services between Guy's and St Thomas' but retained coherent hospitals on both sites and utilised the almost finished Philip Harris House close to its original purpose. They developed two plans one which retained A & E at Guy's but had high revenue costs and one which concentrated acute care at St Thomas' and specialist care including paediatrics and obstetrics and gynaecology at Guy's. KPMG saw their first plan as a stage in development towards the second which was less expensive in revenue terms. The Save Guy's Campaign were prepared to accept the first plan but not the second and insisted on the retention of the A & E department to serve the local community.

'Philip Harris House was 5 star accomodation for 2 star patients, a remark which, not surprisingly, incensed the local population and hospital staff alike.'

Meantime the consultation process ground inexorably on, led by the Lambeth Lewisham and Southwark Health Commission (LSHLC), who produced a

document entitled 'Looking to the Future'. In this they proposed, on the basis of the Trust's plan, that Guy's be reduced to an out-patient department and all our in-patient beds move to St Thomas'. This change involved a change of use of two thirds of the £140 million Philip Harris House. During one of the furious consultation meetings at which these proposals were debated, the Chief Executive of the LSHLC declared that Philip Harris House was '5 star accommodation for 2 star patients', a remark which, not surprisingly, incensed the local population and hospital staff alike.

The Save Guy's Campaign submitted a detailed rebuttal of the proposals in the LSLHC document. They argued the continued need for our A & E department which continues to receive 60000 new attendances each year, twice as many as at Bart's and larger than any other A & E department which has ever been closed in this country. The Campaign pointed out that the first of KPMG options provided an alternative solution which would meet the needs of the local population and serve the interests of the Medical School better.

The consultant staff of Guy's have been represented on the Save Guy's Campaign by the site review committee which I have had the honour to chair. The site review committee also submitted a detailed response to LSHLC document entitled 'Looking to a Better Future' which argued that the KPMG proposals to retain Guy's were preferable to the LSLHC proposals to close Guy's on 15 of 16 points of comparison. On the 16th, the question of space for the whole of King's College Life Sciences departments it had to be admitted that the additional retention of a major hospital facility at Guy's would lead to the need for extensive new build on the Guy's campus. By the end of the consultation process the HEFCE had decided that they could not afford to move the King's Life Sciences departments to Guy's in any case. Thus on all major points of comparison, the option of keeping Guy's open won hands down.

These arguments persuaded the LSLHC to modify their proposals in some important ways. The A & E department was to be kept open until new facilities in surrounding hospitals had been put in place, until primary care had been improved, and until the London Ambulance Service had also improved. They insisted that it should not close in any case until 1999 instead of 1996 which had been our Trust's intention. However these modifications fell far short of what the Save Guy's Campaign set out to achieve. Although hailed as a reprieve, in reality this was only a stay of execution. It still left at Guy's only

an out-patient facility, day case surgery, and an elective orthopaedic unit, dangerously isolated without an intensive care unit.

The LSHLC conclusions were next considered by the Regional Health Authority who went through the motions of listening to our arguments but merely rubber-stamped the LSHLC proposals. The Secretary of State has appointed the officials who were charged with making the decisions about her proposals at each stage of consultation: the Chairman of the Trust, the Chairman of the LSLHC and the Chairman of the RHA and their Boards.

After the RHAs announcement we lobbied the Members of Parliament and ministers, appealing to them to listen to and take note of the arguments in the hope that common sense would finally prevail. Eventually the Secretary of State made a written announcement of her decision to move the inpatient services from Guy's to St Thomas'. The wording of the announcement showed a very slight softening of the proposal from the LSHLC. According to some optimistic readings it could be interpreted as meaning the retention of more elective surgery than just orthopaedics and of some services for the local population, but the burden of the decision was just what we had feared, the eventual closure of our A & E department and substantial closure of our in-patient beds. The manner of her announcement raised a storm of protest, not just from the defenders of Guy's but also from Peter Brooke defending Bart's and a phalanx of Tory MPs defending Edgware General Hospital. As a consequence the Labour Party have put forward a motion 'to halt the withdrawal of hospital services and to moderate the pace of change in the NHS across London with particular reference to Bart's, Edgware, Guy's and the Brook Hospitals'. This debate will take place later this afternoon. If, as is possible, the Government is defeated, there will be a real opportunity of saving Guy's in a shape which will be

'If the Government is not defeated in this debate, then we will have to live with the Secretary of State's decision. We cannot wait for a new government because by then it may be too late. We will have to turn from the political battle and work to ensure that the best of Guy's is saved.'

recognisable by those of us who have learned here, lived here and who love this great institution.

If the Government is not defeated in this debate, then we will have to live with the Secretary of State's decision. We cannot wait for a new government because by then it may be too late. We will have to turn from the political battle and work to ensure that the best of Guy's is saved. We must make sure that if our cardiac department and paediatric cardiac department and cardiothoracic surgery, likely to be the first casualties, are moved to St Thomas' that they are properly accommodated and that the skill and experience of the Guy's team are retained. We must make sure that our renal department, transplantation unit and paediatric nephrology unit are also preserved when their turn comes to move to the St Thomas' campus. We must make sure that our ICRF-funded oncology unit and the world-famous Breast Unit are not sacrificed by the rearrangements. We must make sure that our Paediatric Specialty services are saved. We must make sure that wherever the politicians make us move, we continue to provide for the medical and nursing needs of the population of Bermondsey and Rotherhithe with whom we have lived and died for more than eight generations since 1725.

Above all we must ensure that the traditions of care and service live on in the institutions of which we are or about to become parts, in UMDS, in the Nightingale Institute, in King's College, and in the Guy's and St Thomas' Hospital Trust. Now we must really 'Give rather than receive': 'Dare quam accipere' as the Guy's Nurses' League has always done.

Professor R.A.C. Hughes
Chairman, Site Review Committee

To mark the passing of an era
there will be a great day of celebrations
on

SATURDAY MAY 11th 1996

*****

The Guy's Hospital Nurses' League are planning a full day of activities at Guy's which will be followed by a

GRAND EVENING RECEPTION
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Reserve the date in your diaries now & contact all your Guy's friends.

Full details will appear in the Gazette early in 1996

MODERN FAIRY STORIES

The Block Of Flats

There was once a block of flats, an H-block if you like. Now this block of flats was not happy with his existence. He was very lonely. He was an old block, you see, and one of the first of his kind, and he had no friends. There were lots of houses and banks and things, of course, but he was bigger than them, and they were frightened of him, and kept away from him. I say he, because he is a he. He thinks and he exists. Poor thing. How would you like to be a tall block, with no friends, and little people inside you painting you, sticking things into your sides, knocking parts of you down, and walking all over you? It is not very pleasant, that's for sure. Anyway, Harry (that's my nickname for him, because he's an H-block), Harry had a surprise one day when the architect who designed him, came around to see him. Of course, Jim (the architect) didn't know that Harry could think just like him; he just came to see if Harry was well.

'How would you like to be a tall block, with no friends, and little people inside you painting you, sticking things into your sides, knocking parts of you down, and walking all over you?'

While Jim was checking Harry over, Harry heard him saying to his workmate that he was constructing a new type of block. A totally new, unheard of design, with lots of coloured paint and a new kind of outside lift. Harry was sure that this block would be a she-block but what Harry was so excited about was that Jim said that the building contractors had chosen and bought a piece of land right next to Harry! Harry was so happy that he smiled all the next day, and passers-by later said that they had never seen a block of flats with so many windows open! Days, weeks and months passed without any sign of building, but then, seven months after Harry had first heard Jim speaking about the new flats, building began. When the new, bright and sparklingly clean block of flats

was completed, Harry was dying to speak to his first ever friend. But how would he be able to communicate, he thought. Eventually he decided. He would whistle. He did, and people below had to cling onto their hats and bags. There was no answer but Harry noticed that his new friend must be crying, because lots of water was dripping down the walls and windows. 'Poor thing,' thought Harry. 'I wonder why she's so upset?' So Harry 'spoke' telepathically to her, as only blocks of flats can do, to ask her what was wrong.

'Oh, woe is me!' she wailed. 'I wonder what woe means?' thought Harry. Alas, Harry was not a classically educated block of flats. 'What's the matter?' asked Harry.

It was a long, sad story that Harriet (well, she's an H-block too) told. Apparently, some of the stone of which she was made was very badly behaved, and it did not agree with her. Or, to put it more precisely, she did not agree with it. It had a lot of nasty habits, such as getting dirty and having to be scrubbed clean by the people living in that particular flat. Of course, this hurt Harriet, but every time it was done, all the nasty stone could do was laugh, which was not very nice, was it? Poor Harriet! What was she to do? Harry suggested kicking that particular stretch of wall out, but Harriet said that she didn't think that was a good idea, because the builders might knock her down then, mightn't they? This crying went on for quite a few days and Harry was getting more than a bit upset. This was his first friend ever, and all she could do was cry! Harry decided that it was time for action. He had stood still for long enough. He put all his strength into shaking himself, and he wobbled and wobbled, and shook and shook, and trembled and trembled, until his foundations began to weaken. If he could not have a friend, someone to love apart from himself (as nice as that was), then he would kill himself, for he could take his solitude no longer (and anyway, he might be able to knock some sense into that naughty stone!). So Harry's old and weather-worn foundations began to crumble. Harry knew his end was near, but he was glad. At last, his sad existence could end (choking stuff this). After much heaving and thrusting, Harry collapsed into a pile of rubble on the ground. No humans were hurt, because it just happened to be a Bank Holiday. As dust sifted down the sides of Harriet, it mixed with the moisture of her tears, so that when Harry reached Harriet's ground floor, he had cemented his first relationship (I indeed apologise for that pun). But this

'After much heaving and thrusting, Harry collapsed.'

was not the end of Harry; this story does have a happy ending. For Harry's self-demolition gave certain planners in the town-hall an ideal opportunity to execute their new plan. Harriet had been a little damaged by Harry's downfall, and it was inevitable that something major had to happen for her to survive. The building contractors' plan was to build a new luxury shopping centre (it was either that or the less popular option of a new Hospital Wing), which would combine the two structures (whom we know as Harry and Harriet) into one. So, after all, Harry would have his first friend, in the closest relationship I would have thought possible!

John S Gilbody

After Peace .... Friendship

During the War Gordon was an RAF pilot, who afterwards became a metallurgist consultant for a German Steel Combine. One of his colleagues was an ex-Luftwaffe pilot and they became firm friends, resulting in him being Godfather to his two sons.

After a very severe illness, Gordon was able to spend two weeks convalescing at the RAF Association's Nursing Home "Sussexdown" in Storrington.

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Then and Now in Psychiatry:

'Liaison Psychiatry'

Modern psychiatry has evolved from the interplay of three components: the causes and cures of insanity, historically based in large asylums and brought into closer association with Medicine through the 1960s and 1970s; the psychiatry of the general hospital; and mental disorders presenting in primary care. This third article in the series Then and Now in Psychiatry is about the second of these.

What is nowadays called 'liaison psychiatry' evolved during the nineteenth century as medical knowledge increased. As physical disorders were described, for instance Addison's disease(s) and Bright's disease by Guy's Hospital Physicians, it became clear that a substantial minority of patients had physical symptoms unexplained by physical disease, (though physical causes were often assumed). Gradually, teaching hospitals appointed their own specialists in mental disorders to take care of the patients whose physical symptoms came to be regarded as somehow attributable to non-physical causes. In the 1870s, Dr George Savage was Lecturer in Mental Diseases at Guy's, while also a Physician at Bethlem. Famous names following were: Dr Maurice Craig and Dr RD Gillespie. It is now clear that every medical speciality has its psychiatric correlate; familiar examples include: Chest pain with normal coronary arteries; Hyperventilation; Irritable bowel; Hysterical fits; Dermatitis artefacta; and Anorexia nervosa. In addition, new syndromes follow the development of new medical specialities; fears of MRI scanning, and rumination about the possi-

'As physical disorders were described...it became clear that a substantial minority of patients had physical symptoms unexplained by physical disease.'

'It is now clear that every medical speciality has its own psychiatric correlate.'

bility of HIV infection, are not uncommon. In the National Poisons Unit base at Guy's Hospital, a joint medical-psychiatric clinic has been established to deal with patients who believe that they have been poisoned despite investigations showing no evidence of this. So one part of 'liaison psychiatry' concerns the 'speciality-specific' disorders. There are two other main parts. First, there is the care of patients impinging on general hospital practice who have behavioural disturbances or who have deliberately injured themselves, most commonly of course by self-poisoning. Secondly, a large number of patients attending clinics with medical/surgical/gynaecological symptoms have psychosocial problems. Dealing adequately with these three sorts of morbidity is impossible unless medical and psychiatric personnel can work well together, and staff exit in numbers sufficient to carry out time-consuming and labour-intensive assessment and treatment. In today's reorganised NHS, responsibility for liaison psychiatric services seems to span several Trusts in many places, since psychiatric work other than liaison work is usually in Trusts separate from the general hospital. This can become an organisational nightmare. Nevertheless, in many hospitals and Trusts there is a determination to deal adequately with the psychological care of all patients. A modern approach suited to the NHS has been summarised in an excellent joint publication of the Royal College of Physicians and Psychiatrists (1); this is strongly recommended, and there is even a separate short section for Purchasers.

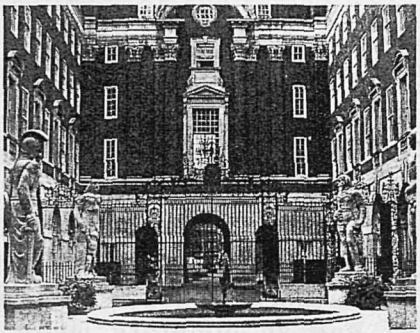
'..Responsibility for liason psychiatry services seems to span several Trusts in many places...This can become an organisational nightmare.'

JP Watson

References

(1) The Psychological Care of Medicine patient. Royal Colleges of Physicians and of Psychiatrists, 1995.

"If you need professional help"...



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Graduation Ceremony

Address by Professor Sir Kenneth Stuart
6 July 1995

This year's address was given by Professor Sir Kenneth Stuart who is currently a member of the UMDS Council of Governors and an honorary medical and scientific adviser of the Barbados High Commission. The following is a transcript of his address:

My Lords, Ladies and Gentlemen, Graduates, this has been a long afternoon for all of you. Let me therefore start this address by assuring you that it will be a short one. My first words must be to offer warm congratulations again to all of you who have graduated today and to wish you for the future good success in both your personal and professional lives. Some of you, I suspect, might also wish that these would be my final words!

'The next century will witness the further evolution of two already existing but widely

But let me take the opportunity I have in giving this address to share briefly with you some thoughts about the world which I anticipate that you and your generation of medical graduates are likely to inherit and work in for the rest of this century and the beginning of the next. I will also indicate what I think might be some of the contributions which you individually and collectively might hopefully make to it.

The next century will witness the further evolution of two already existing but widely differing worlds. Hopefully they will in time adapt harmoniously and come to complement each other; but there are already signs of divergence with the development of potentially destructive conflicts and tensions, which, as we enter the final years of this millenium, already generate a sense of foreboding.

The first of these worlds is comparatively new and is already profoundly different from any we have ever known. David Hamburg, President of the Carnegie Corporation of New York, suggests that it will experience the acceleration and proliferation of influences, many of which are already underway, that will make it more 'deeply inter-dependent, more closely linked technologically and progressively more homogenised through the movement of ideas, information, people and skills around the world'. It will call forth and facilitate an increasing knowledge of people, of each other, and a progressive integration of their cultural and social identities in seeking the fulfilment of shared interests and goals.

Matters requiring countries and communities to pool their efforts - In other words calling for neighbourly action - will keep on increasing and, as the physical and other boundaries that tend to separate communities and cultures are eroded by waves of intellectual and technological changes, cherished notions of separateness, and self-determination, going-it-alone will be progressively challenged and discarded.

Working together towards their shared interests and goals will have potentially powerful unifying effects for otherwise disparate groups and communities. It will lead to benefits which, the world's community of countries is coming to appreciate, can only be achieved through the sharing of information, communication and co-operation. Such shared interests and goals will include, for example, improvement of the health of their people, protection of the environment, stabilisation of world trade, a widening global emphasis on equity, racial tolerance and social justice and several other developments critical for world growth and change. They will lead to the emergence of forms of community sharing, social cohesion, group solidarity and international collaboration on a scale never experienced before.

'Change our fundamental angle of vision and everything changes.'

Already many countries wishing to control their own destinies, find that they can do so only by working together with others. They recognise that they can

secure their future only through commitment to common responsibility and shared effort. The more people accept the logic of the growing inter-dependence of human society, the more ready they will be to seek opportunities to overcome notions of 'otherness' and to find ways of working together. As Barbara Ward said, 'change our fundamental angle of vision and everything changes'.

The other world is one that is already deeply rooted in human society. It will be fed, as it has been for centuries, by powerful currents of in-group/out-group conflicts, aggressive ethnic nationalisms and deepening schisms based on religion, culture, race, colour and a host of other differences.

'Never before have so many peoples and countries had so much in common and yet never before have the issues that divide them been more numerous and threatening.'

This ancient propensity towards harsh and narrow identity is an established heritage of our human legacy. It is already posing more and more disruptive threats to world stability and peace - both within and between countries. It will confront the next century with even greater divisions and hazards, and it will provide even greater challenges for it than those which already confront the end of the present one - challenges which could be equally destructive for both worlds. Never before have so many peoples and countries had so much in common and yet never before have the issues that divide them been more numerous and threatening.

Urgent measures need to be taken on a wide international front, and on a broader scale than has ever been undertaken, to strengthen the first of these worlds and to constrain the second. Perceptions and policies are called for within and between professional associations, academic institutions and community groups, nationally and internationally, that will favour cosmopolitan rather than parochial or narrowly defined identities. That will promote sympathetic inter-group contact, mutual respect and overlapping loyalties; that will

eventually bring to the world not only aspects of a global village, but of a safe sanctuary for all its people as well.

Groups of many kinds are already reaching out and establishing counterparts in other parts of the world. The emergence of the concept of a global society is an important pre-condition for neighbourliness at the global level. More and more people and institutions are making connections across borders and developing relationships based on common concerns and issues. Diversity needs not become a cause for division.

'Medicine is international. The fight against disease and, more importantly, the securing of good health, cannot be confined within national boundaries.'

The world medical community has an admittedly small but unique role to play in both the initiation of this process and in the provision of a model for the action that other groups, governmental or non-governmental, might follow worldwide. Its success will depend on the small, discrete, sometimes apparently unrelated efforts of many individuals, groups and governments.

Recognition, treatment and prevention of disease should only be part of the remit for the world's medical community. In his 1993 commencement address to the graduating class of St George's University of Medicine in Grenada, the late Lord Pitt stressed that 'Medicine is international. The fight against disease and, more importantly, the securing of good health, cannot be confined within national boundaries'.

Sharing as it does certain basic interests, values, educational standards and goals, medicine functions in a field that has no inherent barriers. It can help to strengthen and harmonise the already unifying influences of the first of the worlds I have just described and to lessen the tensions and divisions of the second. It can help people to move towards a wider sense of social identity and to interact on a basis of mutual benefits and respect.

Taking turns, sharing, communicating, co-operating especially in learning and problem-solving can open a way for medical staff and students alike to beneficial human relationships. It can chart a path through different cultures and assist people of diverse backgrounds to learn to work and live together, to gain a sense of a shared humanity.

'...Your medical education to date might not have prepared you as fully as it might have.'

One of the roles I particularly enjoy as a member of the council of UMDS is membership of a committee convened by the Principal and Professor Hay which has this international reach as one of its special objectives. It seeks to provide opportunities for staff and students of medical schools of a number of countries to collaborate in strengthening international co-operation in medical education and research.

The role of you, today's graduates, in these developments, I must remind you, will depend as much on your own efforts, on your own self-education and motivation as on the medical education you have had so far, excellent as I am confident that it has been. Indeed, in the context of this role, your medical education to date might not have prepared you as fully as it might have.

A possible shortcoming in contemporary medical education has been suggested by two of this country's most distinguished physicians, one a past and the other the current Regius Professor of Medicine at Oxford University, one near the beginning, the other near the end of the present century.

'Ask at what he is working, and the student will answer; for his first MB or for his Finals.'

In his address delivered at the opening of the winter session at St George's Hospital Medical School in London in 1915, Sir William Osler had this to say:

'Medicine is the only one of the great professions engaging equally head and heart in hand. To an inquisitive mind the study of medicine may become an absorbing passion full of fascinating problems so many of which present a deep

human interest. In the long category of man's conquests none are more brilliant than those with which a teacher of medicine can inspire his class. It is hard indeed to name a dry subject in the curriculum: and yet in an audience of medical students such a statement nowadays raises a smile. Why? Because we make the examination the end of education, not an accessory to its apposition. The student is given early the impression that he is in the school to pass certain examinations; and I am afraid the society in which he moves grinds this impression into his soul. Ask at what he is working and the student will answer; for his first MB or for his Finals. We have become quite shameless about it and practically admit a failure in our teaching. The spirit is taken out of instruction and teachers and taught alike go down into the valley of Ezekiel where they stay along the dry bones'. That was Sir William Osler in 1915.

In an editorial in the British Medical Journal earlier this year, Sir David Weatherall made this comment about contemporary medical schools and the education of Doctors:

'Have we, albeit unwittingly, evolved an educational system that, from the very beginning, is destined to leave many of its products ill-equipped to deal with the multi-faceted needs of people?

'...no medical school can teach a young person how to be understanding and caring. This can come only from experience of life.'

Undoubtedly a core of facts is required to practise medicine together with communication skills and an understanding of social and ethical issues, can be taught - a process that can be continued during postgraduate training. But, except by example, no medical school can teach a young person how to be understanding and caring. This can come only from experience of life. Perhaps it is this above all that we have neglected as we push our brighter young people through the hot-house of modern medical education without giving them time to reflect on what their profession is all about'. That was Sir David Weatherall in 1995.

Ladies and Gentlemen, these statements made nearly a century apart, and by two highly eminent and dedicated medical educators, suggest that as far as the medical curriculum at any rate is concerned, there has been little if any progress

in the interval between them. They define a long recognised medical educational goal, a goal for which humanity is as important as science, a holy grail that has yet to be reached in spite of remarkable medical scientific progress in the intervening years.

I am reminded of the words of Bernard Shaw: 'Hanging on a pendulum, swinging to and fro, mistaking movement for progress'. It will be up to your generation to help to bring progress to the movement of which you today became a part; to have the self-assurance to break with the past, the courage and optimism to do things differently, the confidence that what you can do will make a difference. I would suggest that a good beginning might be for each of you as a personal responsibility to ensure that his or her continuing medical education, whatever form it takes, should become not only an educational, but a humanising experience as well.

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HENLEY ROYAL REGATTA

After a strong and committed row in the bumps, preparation for Henley was delayed by a couple of weeks while members of the crew tried to salvage the academic side of things. A week or so later the crew got back into the daily waterwork that would be crucial in determining whether we would be quick enough to qualify. Could we translate our fitness into boat speed? The crew showed good commitment during those busy few weeks; everyone had exams, yet managed to keep juggling their work, rowing and everything else. It is a perennial problem; the first years in the crew (no less than three!, potentially had a pass/fail viva on race day), other members of the first squad got round the work problem by breaking so many bones that rowing was impossible (Sidd - playing 'chicken'on a bicycle against an articulated lorry was never really going to be a fair contest). The day of the qualifying race. No messing around. This was it; the prize we had worked hard towards.... ....To qualify. After a change of crew in the Visitors' four, theirs was the first race. With 'slippery' McCready setting a strong rhythm, and under the careful guidance of steersman Gray, the four had a rocky start, but soon came together, settling to a rating of about 36. In the middle of the boat, those trusty workhorses Baird and Arnold were laying down some hefty work; we all tried to keep it quick and lively. The boys crossed the line tired, but generally pleased with a good 'technical' row. Next up, the more important of the two races; UMDS Men's 1st VIII trying to qualify for the Temple Challenge Cup. After a final, unfortunate crew change about a week before race day, we all felt quite apprehensive, knowing that the preceding few days hadn't been us at our best; if only we could recapture the form we had in the bumps.... It wasn't a particularly good row. I think it's probably fair to say that we had a jittery start, and a jittery finish, together with a pretty jittery bit-in-the-middle. Ironically, I'm confident that everyone put everything into the race; we were all exhausted before the finish line (as you should be). The problem is that we didn't do it together, and we weren't practised enough to be able to come to Henley knowing that if we 'did the business', that we would qualify. We also managed to find a few corners in this 'straight-as-a-die' course, an understandable, if frustrating reflection of inexperience. We didn't qualify in either Visitor's, or the Temple Challenge Cups. Henley Royal Regatta remains the most prestigious race in the British rowing calender, the 'Holy Grail', if you like. Each year the number of entries grows, the proportion of international crews grows, and yet the number of places in the regatta is limited. Thus it is harder than it ever has been to qualify to race there; this year we were the only hospital crew in the

country to try. It will remain at this high (international) level until either the regatta is extended from five to six days, or some kind of restriction is put on international entries. Nevertheless, it is possible to qualify, and we will do our very best to do so in June 1996.

Richard Baird

UMDS Boat Club

Fixtures List 1995/6

Date	Race	Location
17/9/95	Boston Rowing Marathon	London, Tideway
29/10/95	Janousek Fours Head	London, Tideway
4/11/95	Fours Head of the River	Cambridge *
18/11/95	Cambridge Winter Head	London, Tideway
Dec 95	UL sprints	London, Tideway
Dec 95	UH sprints	London, Tideway
27/1/96	Cambridge Head to Head	Cambridge *
Jan 96	UL Head	London, Tideway
Feb 96	UH Head	London, Tideway
9/3/96	Reading University Head	Reading
23/3/96	Kingston Head	London, Kingston
30/3/96	Head of the River	London, Tideway
May 96	UH Bumps	London, Tideway
May 96	Metropolitan Regatta	London *
June 96	Docklands Regatta	London, Docklands *
June 96	Reading Amateur Regatta	Reading
June 96	Marlow Regatta	Marlow, Bucks
June/July 96	Henley Royal Regatta	Henley-on-Thames

* To be confirmed

Rugby

Fixtures List

Courage League Fixtures....1995/1996

London League Three SouthWest

September 16.... Old Guildfordians v Guy's Hospital

September 23.... Guy's Hospital v Gosport

September 30.... Warlingham v Guy's Hospital

October 21..... Guy's Hospital v Old Emanuel

October 28..... Cranleigh v Guy's Hospital

November 11..... Guy's Hospial v Portsmouth

January 6..... Old Walcountians v Guy's Hospital

January 13..... Guy's Hospital v Alton

February 10..... Old Alleynian v Guy's Hospital

February 17..... Guy's Hospital v Jersey

February 24..... Old Whitgiftians v Guy's Hospital

March 30..... Guy's Hospital v Purley

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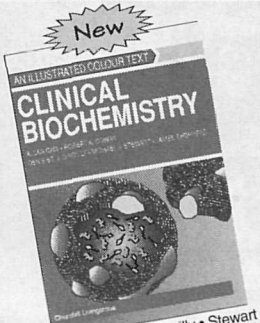

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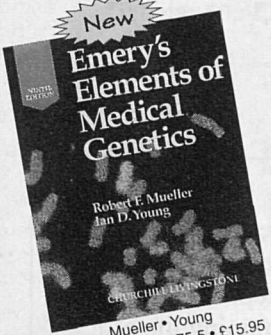

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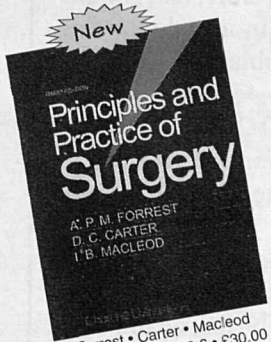

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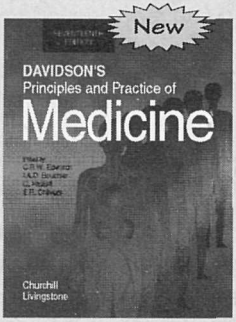

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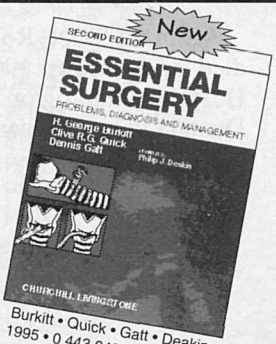

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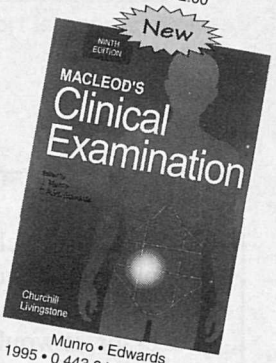

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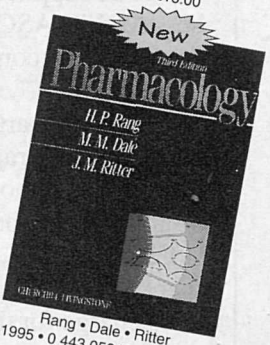

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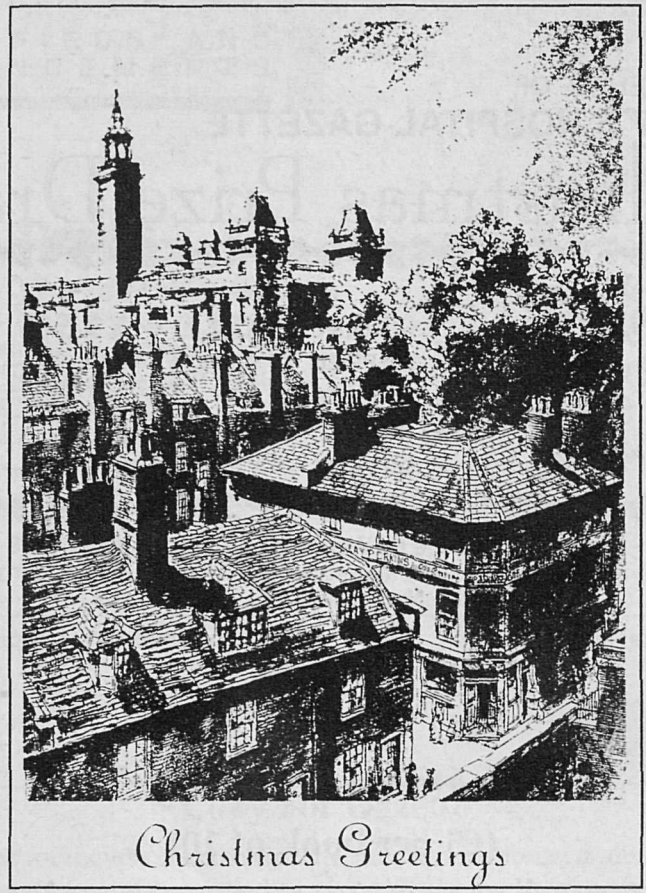

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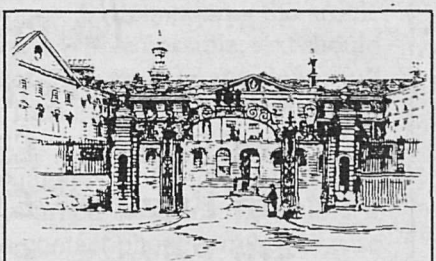
Christmas

Greetings



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Guy's Gazette

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Passim

We live in an era which is becoming more and more revolutionised by technology and electronics, and it is no wonder that we may have difficulty in recalling how the great institutions that we have today, have become so.

Here at Guy's, we have been privileged to have been graced by the pioneering industry of many great clinicians. Forthcomingly, the triumvirate of Addison, Bright and Hodgkin and of course, AstleyCooper arguably one of the finest surgeons of his time. These fine men are at the foundation of the greatness of our hospital. However, it has not only been our clinicians that Guy's Hospital has been home to, and to this list of alumni we must add another. His contribution to medicine would have been exemplory,were it not so brief, and although he has no eponym, his legendary nature is honoured here at Guy's. This month we are proud to celebrate the bicentennial anniversary of his birth, John Keats was a Guy's man!

In spite of our immense history, we can not live in the past, we must look ahead to the future, and therefore we extend a very warm welcome to the new fresher fledglings. We hope that your time here is both successful and memorable. If there could be one piece of advice to offer, it would be, work hard and play hard. Enjoy.

Guy's Castle

Dear Sir,

It is not just institutions constructed or inspired by our founder, Thomas Guy, that are threatened by alteration and new ownership. I was recently sent details of a house Guy owned in the beautiful Wye valley - an absolute bargain so it seems at just £250,000. Guy built the house in 1731 and, like our new hospital complex, erected and integrated it with an older building which he purchased, Wilton Castle. Like recent events in London, the proposed sale of Guy's Welsh home also made front page news in the Western Mail (15th July) which headlined "When a Guy's house is a castle." The history of Guy's house and castle bore striking and touching similarities to his hospital for the incurable in Southwark. Both were built next to strategic river crossings to protect travellers as well as local inhabitants. Additions and extensions had been tastefully made over the past 270 years so that even today it remained a family residence of enormous character. The article went on to inform that at one time Guy's castle had been attacked by royalist forces, Indeed it had been all but burnt down in the Civil War only to rise again. Interestingly, when resurrecting his home, Guy maintained its connections with a set of dungeons in the remains of the castle by means of underground passageways. Apparently they were never used though, if any alumni care to buy this house, names for new occupants immediately spring to my mind.

Yours faithfully,

Michael Gleeson.

Students' President?

Dear Sir,

I am writing concerning inflammatory remarks made about myself in the July edition of the Guys Gazette by Oliver Harley, the former Student President.

The article was intended to relate to the work done by the Students Union for that year. And in some respects it did this very well. What it also did was to prove that this particular student has an unerring knack of hurling slanderous mud at his friends and colleagues.

I probably was not the best Sports Representative there has ever been on the Students Union but I was certainly not the worst.Throughout the whole year I did not hear once from our illustrious President that I was doing a bad job. It seems he would rather wait until he had finished his term before he aired his views. This inability to convey his personal ideas, feelings and especially his grievances directly to the appropriate person was apparent throughout his term in office. (It was not difficult to spot where the ideas he was conveying came from).

Time and again he would try and enforce changes to student life at UMDS without any consultation with the students he was meant to be representing. I did think it uncanny that most of the changes he wished to enforce were also strongly supported by members of the staff hierarchy at UMDS.This, I feel, is the biggest failure anyone can make when holding such a position as Student President .

I wish Tom Witcher, the incoming President, the best of luck for the coming year and hope that he will represent the opinions of the students.

Yours faithfully

Peter Davis,
4th year dental student

CAREERS FAIR FOR MEDICAL STUDENTS

The Royal Society of Medicine is organising a free Careers Fair for medical students on the 16th January 1996. Issues discussed will include: The Calman Report, future issues, Senior House Officer options, GP Training Schemes, full and part-time options, research options, General Practice, Doctors as managers/controllers of budgets, communication in medicine and medicine in ten years time.

Participation in the 1996 Careers Fair is free, but in order to take part, you must register. Registration forms are available from: Mrs Alyson Ling, The Royal Society of Medicine, 1 Wimpole Street, London W1M 8AE. Tel: 0171 290 2985. Fax: 0171 290 2989.

FAREWELL TO BROOK LODGE WARD

Brook Lodge Ward, the long-stay ward in Hunts House, has been closed and the patients have been moved into a newly refurbished privately owned nursing home at Burgess Park. The home has nine single rooms for NHS patients from Guys plus three respite places.

THE ANNUAL DENTAL DINNER & BALL

Guys Dental Society are holding their annual ball on Saturday 11th November 1995 at The London Hilton, Park Lane. Tickets are £95 per double and are on sale now at lunchtimes on floor 24 Guys Tower. Please come along and book your tables (10 persons per table) well in advance as tables are going rapidly.

Anyone not able to purchase tickets on the 24th floor of the tower can obtain tickets by phoning Dominique O 'Leary on 0956 828 603.

FACELIFT FOR GUYS A&E

A brand new reception and waiting area has opened in Guys A&E as part of the work currently in progress on the new main entrance to New Guys House, Guys Tower and the infamous Phase III (when will this phase ever be completed!!). The new reception area is a much needed improvement on the old one creating a more pleasant atmosphere for both the staff and patients on entering. Added extras include a TV for patients awaiting treatment.

UMDS Research Day

This years annual research day is to be held on the 1st November at the Harris Lecture Theatre. The theme for this years meeting is Developmental Neurobiology. UMDS has a very strong interest in this field of research and this year's event will be host to a selection of leading speakers from around the world.

Keats Exhibition

In celebration of the bicentennial anniversary of the birth of one of the worlds greatest poets, The British Library is holding an exhibition of the life and times of John Keats, in association with the Wordsworth Trust. The exhibition is being held in the Crawford Room, The British Library from the 18th October until 28th January 1996.

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JOHN KEATS AND OTHER DOCTORS

Dissection, Poetry and Consumption

John Keats is, without doubt, the most famous Guy's medical graduate though of course his fame is due to his poetry, and not for his medical achievements. This year is the bicentenary of his birth. He was born on 31 October 1795 and celebrations to mark this anniversary have been held all over the world. It is perhaps surprising to realise that lectures, conferences, poetry readings and exhibitions have been arranged in countries such as the USA (where there are many Keats devotees), South Africa, Australia and others including, rather strangely, Japan. During the summer, at the Keats Museum in Hampstead, organised by the Curator, Mrs Christina Gee, there have been a number of lectures about his life, and at the Wordsworth Trust in Grasmere, a wonderful centre of information about the Romantic Poets, Dr Robert Woof, the Director, and his staff have produced a magnificent Keats Exhibition which will move to the British Museum in October.

It is appropriate that the Gazette should mark this important anniversary because Keats' association with Guy's (although lasting less than a year) and with medicine generally formed a significant part of his life and influenced his writing.

John Keats' parents lived in Moorgate. His mother, Frances, was the daughter of John Jennings who kept a busy inn, the Swan and Hoop. Businessmen living in the country would travel to the outskirts of London in their carriages, leave them at the stables of the Swan and Hoop, and walk to their offices in the City. The head ostler, Thomas Keats, originally from the West Country, had married his employer's daughter. Their first child, John, was baptised in the nearby church of St. Botolph's-Without in Bishopsgate. The incumbent priest, Dr Conybeare was probably the first doctor he encountered, albeit a

Doctor of Divinity, not medicine, and a forbear of our own Sir John Conybeare, a prominent physician well known to older Guy's men.

Thomas and Frances Keats had four more children, George, Thomas, Edward (who died in infancy) and Frances. The family was reasonably well-off and the parents originally wanted to send their sons to Harrow School, but, probably because the fees were beyond their reach, they decided that John and George should go to a small boarding school in Enfield run by Dr John Clarke. Keats started there at the age of 7.

He had been at Dr Clark's school for only 3 terms when he received the terrible news that his father had died from a head injury caused by falling from his horse. Within two months his mother had married again, a man called Rawlings about whom very little is known. Not long after this his grandfather John Jennings died and, disapproving of his daughter's second marriage, he left the bulk of his estate to his widow and their surviving son Midgley John Jennings, a young naval officer. Frances, understandably, was not pleased by the terms of her father's will and embarked on a long lawsuit against her own mother and brother. Soon afterwards she left the Swan and Hoop which she had been running with her new husband and saw very little of her children over the next two years.

Keats grandmother, Mrs Jennings, had moved to Edmonton, then a quiet, rural village only about 2 miles from Enfield, so had her grandchildren, and the boys would stay with her during the school holidays. At school John was having an undistinguished career. He was small, had reddish-brown hair and a lively temper. He was frequently involved in fights and more interested in cricket rather than study. He showed little inclination to work. In 1808 his mother re-appeared. Her brother, Midgley John, who had been largely responsible for carrying out the instructions of their late father's Will had begun to show signs of tuberculosis and, probably as a consequence of deteriorating health, wanted to become reconciled with his sister. Francis had by now left Mr Rawlings and the family was united again, only to be shaken once more by the death of Midgley John.

Keats, delighted by the return of his mother, began to work much harder at school. So much did he change that he read every book in the library, became accomplished in the classics, and won a prize given by the headmaster for work done outside the curriculum. Tragically, at the time when he began to flourish academically and show signs of his literary gifts, his mother's health began to

fail. During the holidays at the end of 1808 he spent all his time attending to her needs. He sat with her, fed her, ran errands and read to her. At last, after a long period of absence and emotional deprivation, the bonds of love between Frances and her eldest son were being forged again. How terrible it was for John (and his brothers and sister) that while he was back at school in February 1809 his mother had died of consumption. He was 14. So far, in his short life, he had already lost both his father and his mother. He must have been moved, earlier, by the death of his grandfather but he probably would not have been much affected by that of his uncle Midgley John. He would have been too young to have known his other uncle Thomas, who died as a boy, but when Edward, his third brother, died John was 6. Early deaths, three from tuberculosis, and of close members of a family were much more common then they would be now, but no less tragic for the children concerned. Keats had also experienced great unhappiness by being parted from his mother and had doubtless felt the strains in the family produced by dispute over his grandfather's Will.

'Although in his earlier schooldays he was not well behaved he was a star pupil by the time he left school.'

It is perhaps surprising that these disastrous events did not appear to have such an adverse effect upon his adolescent development as might have been anticipated. He did not, as he might well have done, become anti-social, unpleasant or difficult. Although in his earlier schooldays he was not well behaved he was a star pupil by the time he left school. His resilience is intriguing but it has been suggested by Professor Anthony Cox (1) that a number of (now well recognised) protective factors were operating. These are Keats' above average intelligence, his academic success, and the closeness and affection of his grandmother.

At the age of 14 and 7 months he left Dr Clarke's school and became apprenticed to Thomas Hammond, an apothecary in Edmonton. Hammond was the family doctor and looked after Mrs Jennings who lived nearby. Keats' decision to become an apothecary was undoubtedly a positive one with no evidence of pressure from other sources and possibly influenced by experiences when he looked after his mother in her final illness. The premium paid to Hammond was 210, a large sum, which came from the modest funds held in Trust by his guardian.

Hammond lived in a house in Church Road, Edmonton and Keats stayed in a small cottage in the grounds. An apprentice would have spent his time assisting his employer, initially performing menial tasks on the premises but, with more experience, dressing wounds, dispensing simple medicines, perhaps lancing boils and even seeing servants in the area of the practice and judging whether it was necessary for Mr Hammond himself to make a visit. Keats would have often accompanied Hammond on these.

He was allowed time off and he spent most of his half days at his old school in the company of Charles Cowden Clarke, the Headmaster's son, with whom he had become very friendly. He would walk to Enfield across two miles of countryside, very much aware of the flowers, trees and animal life, that he would observe on the way. At his old school, he would read, talk and write with Charles Clarke, and sometimes be invited to stay for dinner with him and his father. He must have enjoyed these visits enormously. They continued throughout the 5 years of his apprenticeship and greatly broadened his education in English Literature, the Classics and Liberal Politics. On one such visit in 1809, Clark introduced Keats to Spencer's 'Faerie Queen' which had a huge impact on him and like another, similar, experience some years later, also with Clarke, probably played a major part in stimulating his interest in poetry.

At the beginning of October 1815, shortly before his 20th birthday, Keats entered Guy's as a student and signed the Register, paying a fee of £26. Thomas Hammond had himself been a student at Guy's and, although during the latter part of the apprenticeship he and Keats were not always on the best of terms, it is likely that this played a part in the choice of hospital. This was the first year of new regulations in the training of apothecaries, designed to formalise and improve the curriculum which had hitherto been haphazard and unsatisfactory.

Keats entered lodgings in Dean Street (now Stanier Street), close to Guy's in an area of London at that time of great poverty, poor buildings and mean, dirty streets. Students were required to attend lectures in anatomy, surgery, medicine materia medica and botany. The United Borough Hospitals of Guy's and St Thomas's were on either side of St Thomas' Street. Students and staff would cross the road, moving freely from one to the other. Anatomy and surgery lectures were held in St Thomas's, those in medicine and materia at Guy's.

Keats appears to have been a popular and diligent student. Some of his notebooks still exist (in the Keats Museum at Hampstead) and show that he took neat and assiduous notes in anatomy and what passed for physiology. The star performer among his teachers was Astley Cooper who was the leading surgeon and teacher of anatomy in Europe. A tall, commanding figure with great presence, he had risen to the highest status in British surgery through immense industry and attention to detail. He came from a medical family, his uncle being a Guy's surgeon, spending his early life in Norfolk accounting for the accent which he never lost.

'Some lectures were not so exciting and his attention would wander. Notes on bones of the foot were embellished with drawings of flowers...'

Cooper did not allow a day to pass without undertaking dissection, usually early in the morning. He would declare that a precise knowledge of anatomy was essential to successful surgery. He had an immense practice from which he derived a considerable income, but much of this was used to further his teaching and for the benefit of his hospital and students. His lectures were attended by huge and enthusiastic audiences and Keats recorded many of his obiter dicta. For example:

Mr C says 'Fractures of the neck of the femur occur in elderly people and he had never seen one unite, though Mr Abernethy was of a contrary opinion'. And

'Ossification of arteries is a constant effect of age. The young, who lead a life of intemperance are subject to ossification, those who have been much addicted to study, from keeping up a continual determination of blood to the brain, have often the vessels of that part ossified.'

Some lectures were not so exciting and his attention would wander. Notes on bones of the foot were embellished with drawings of flowers and he wrote one of his earliest poems on a page of the notebook of his friend Henry Stephens with whom he shared lodgings.

'Give me wine, women and snuff,
Until I cry 'Hold enough!'
You may do so sans objection
Until the Day of Resurrection'.

The page of the notebook upon which this is written is now in the library of Trinity College, Cambridge.

Medicine, chemistry and materia medica were taught by the Guy's physicians. It has been suggested that William Babington, a fine teacher, kind doctor and very experienced clinician was one of Keats lecturers but Dr Babington had retired from the staff of Guy's in 1811 because of the demands of his large and expanding private practice. The physicians whom Keats encountered were Alexander Marcet, Henry Cholmeley, James Laird and James Curry.

'Cholmeley despised the stethoscope, as did many of his contemporaries, and refused to have anything to do with it.'

Alexander Marcet was the son of a Swiss merchant and was born in Geneva but left Switzerland in 1793 during a revolutionary period and was later imprisoned for publicly opposing the popular party. The sentence was commuted to banishment for 5 years and he travelled to Edinburgh in 1794 where he graduated MD in 1797. Like many medical graduates of his day he then came to London where he practiced for some years in the City while writing papers on various medical topics and helping to found the Medico-Chirurgical Society which later became the Royal Society of Medicine. He was appointed physician at Guy's in 1804 and resigned in 1819. He became a Fellow of the Royal Society and had a considerable reputation as an experimental chemist. Among the work for which he was well known was extensive investigation into calculous diseases and many specimens of his exist in the Gordon Museum. Dr Marcet described a hitherto undescribed substance which he called Xanthine.

Henry James Cholmeley was born in 1777 in Lincolnshire and educated at Westminster School and Oxford where he took degrees in Arts and Medicine. He became a Fellow of the Royal College of Physicians in 1810 and physician to Guy's in 1811. He gave lectures in medicine and in 1820 with William Babington wrote a book entitled 'Outlines of a Course of Lectures on the Practice of Medicine'. This was dedicated to Mr Benjamin Harrison the celebrated Treasurer of the hospital who more than any other single person had an immense influence on the development of Guy's as a teaching hospital in the first half of the 19th century, and who was largely responsible for appointing

a succession of brilliant men to the staff, including, later, Addison and Bright, although he made a mistake in failing to appoint Hodgkin.

Cholmeley was a good practical physician and his favourite medicine was 'the white mixture' containing magnesium carbonate and sulphate and it is said that his ward rounds were followed by a great commotion of patients getting in and out of their beds in response to the generous dispensing of this purgative. Cholmeley despised the stethoscope, as did many of his contemporaries, and refused to have anything to do with it. The staff of the hospital were surprised one day when he arrived flourishing a new stethoscope, and placing it on a table inserted a flower saying 'What a capital bouquet holder'. He was jealous of Astley Cooper's success and reputation and publicly accused him of developing the new medical school for personal advancement. Cooper was furious at this and demanded either an apology or a duel. Eventually Cholmeley apologised.

James Laird, another graduate of Edinburgh University was appointed assistant physician to Guys in 1813, full physician in 1819 and resigned as a result of ill health in 1824. Very little is recorded about him and it is not known how much part he took in the teaching of students at the time when Keats was at Guy's.

Perhaps the most interesting of the physicians was Dr James Curry, like Babington an Irishman, but a Cambridge graduate with a rather foppish appearance which belied an extremely sharp intellect. He was widely respected by his students and colleagues. Although Dr Cholmeley had dedicated his book to Benjamin Harrison he had wanted to perpetuate the doctrines and teaching of Dr Curry who had been his predecessor. He said 'Doctrines of a physician of such pre-eminence, of such indefatigable zeal and ardour, of such acuteness of mind and brilliancy of talent, so great truthfulness of observation should not be permitted to die with him'.

Curry regarded himself as an expert on disease of the liver - perhaps he was the first Hepatologist - and, since little was known about liver function, he was not often challenged. He firmly believed in the therapeutic efficiency of Calomel (Mercury), prescribing it for most conditions but particularly when he diagnosed liver disease. He was known at Guy's as 'Calomel Curry'. Curry was a good lecturer but it is not known how much influence he, or that of Marcet and Cholmeley, had on Keats.

Students at that time would study botany during the summer, when it was too hot to work in the dissecting room which was smelly enough in the winter. Botany formed a significant part of the curriculum since herbs were widely used in medicines and medical men would be expected to know about them. Whether Keats attended lectures or field studies in this subject is not clear. What is obvious, however, is his deep and detailed knowledge of plants, trees and flowers, much of which was acquired earlier in his life but probably enhanced by his exposure to scientific training.

'Billy...was tall, clumsy and shambling and also deaf. He knew little anatomy and although a kind man was an inept and dangerous surgeon...It has been suggested that the harrowing experience of working for such a bungling surgeon played a big part in Keats' decision to abandon medicine.'

Keats made an early favourable impression as a student. Astley Cooper apparently noticed this short young man with curly brown hair and arranged for him to be taken under the wing of two senior students whom he joined in lodgings above a tallow chandler's shop in 28, St Thomas's Street. These were Fred Tyrrell and Henry Cooper, nephew of Astley Cooper, to whom they were both apprenticed. By his own industry and helped by his association with these more senior men, Keats was offered early on the opportunity to become the dresser to one of the surgeons when a vacancy arose. He had to wait until March 1816 and then had to pay a fee of £50 which his guardian handed over with some reluctance. Dressers had a higher status than ordinary students and often went on to become surgeons after a period spent working with a senior surgeon on the staff of the hospital.

Keats may well have hoped that he would be a dresser to Astley Cooper but the vacancy, when it came, was for a dresser to one of the other Guy's surgeons, William Lucas Jnr. Lucas was the son of William Lucas Snr. who had been a distinguished surgeon at Guy's and who had arranged, as was often done in those days, for his son to be appointed to the staff upon his own retirement. Lucas Jnr. known to all as 'Billy' was very different from his father and as unlike Astley Cooper as could be imagined. He was tall, clumsy and shambling

and also deaf. He knew very little anatomy and although a kind man was an inept and dangerous surgeon. Cooper was always anxious when he knew Billy was operating, which was fortunately, not very often. Keats, as Billy's dresser was expected to look after the day-to-day management of his patients, following his chief around the wards carrying a box of dressings and plasters, and seeing patients in the out-patient department.

It has been suggested that the harrowing experience of working for such a bungling surgeon played a big part in Keats' decision to abandon medicine. This seems unlikely to be the whole explanation but when, in July 1816, he passed the examination of the Apothecaries licensing him to "practice in the country" he gave up a medical career to concentrate on writing poetry. On one or two occasions subsequently he made passing references to returning to medicine but for practical purposes it was completely abandoned. Many people have speculated about his reasons but it is probably quite simple. He had an overwhelming interest in poetry and a great desire to write. He believed he would be very successful. While he was a medical student he met an increasing circle of friends in the world of the arts. Charles Clark, who had introduced Keats to the radical weekly paper 'The Examiner' while he was at school (and which he subsequently read throughout his life) arranged for him to meet its Editor, Leigh Hunt, and he became absorbed into his circle. Clarke, who had earlier shown Keats the 'Faerie Queen', at about this time spent an evening with him reading Chapman's translation of Homer. It was late when they parted but Keats, enchanted by the experience, returned to his lodgings with composition flowing through his mind and by breakfast the next morning on Clark's table was the poem 'On the First Looking Into Chapman's Homer', which was a new, confident, and brilliant step in the next phase of his career. What effect upon his poetry did Keats medical training have?

This question has often been asked and his works dissected and pored over to find medical allusions. They are not easy to find. His detailed knowledge of botany certainly emerges in many of his poems. Broadly he was critical of science but had an acute appreciation of natural phenomena and of changing seasons, creation, decay and death. His powers of observation, a crucial part of medical training, are strongly developed as in his sympathetic approach to human suffering.

From July 1816 however, his world was one of his brothers and sister, his many friends outside medicine, travelling widely in England and concentrating upon making a success of his new life. His first published poem written in 1815, appeared in 'The Examiner' (1817) and reflected his feelings about living in the Borough:

'O Solitude! if I must with thee dwell,
Let it not be among the jumbled heap
of murky buildings.....'

He moved into lodgings in Cheapside with his brothers, having spent some time in Margate with Tom. By the end of December 1816 Leigh Hunt was referring to him as the 'promising young poet' and in the following year had shown examples to Shelley and Hazlitt. In March 1817, now living in Hampstead with his brothers, Keats had his first volume of poems published. Sadly these were not well received and he went to the Isle of Wight to plan Endymion. Again he went to Margate to Tom then back to Hampstead and by August parts I and II of Endymion were written. September and October were spent with a friend in Oxford where he wrote part III and in December, with great joy, he met Wordsworth who had already read some of his poems.

'I know the colour of that blood; it is arterial blood. I cannot be deceived in that colour. That drop of blood is my death warrant. I must die.'

1818 was a busy and eventful year. Tom coughed up blood and during March and April he and John stayed in a small house in Teingnmouth. In June John went on a walking tour of the Lake District and Scotland with his friend Charles Brown. In August they climbed Ben Nevis. Soon afterwards John began to have chills and troublesome sore throats and returned to London alone only to find that Tom was now very ill clearly due to tuberculosis. By November Keats had met Fanny Brawme to whom he later became engaged. On 1st December Tom died.

In spite of the sorrow at Tom's death the early part of 1819 was a much more settled and productive year. He wrote most of his major odes and his last, "To Autumn", was finished in September. After that he produced almost nothing so that most of his writing had been in the short space of three years between 1816 and 1819.

In November he moved into Wentworth House (now the Keats Museum) at Hampstead at the invitation of Charles Brown with whom he had stayed for short periods before. Fanny Brawme (to whom he was now engaged) and her mother were living in the other half of the house. By December he was beginning to feel "rather unwell".

In February 1820 after a journey on a coach from London in cold weather he coughed up a small amount of blood onto the sheet of his bed. He said 'Bring me the candle, Brown and let me see this blood'. They looked at it, Keats then said, 'I know the colour of that blood; it is arterial blood. I cannot be deceived in that colour. That drop of blood is my death warrant. I must die'.

Later that night he had a massive haemorrhage from the lungs and thought he would die then, drowning in his own blood. He was attended by a Dr Rodd who practiced in Hamstead High Street and had been summoned by Brown. He survived that episode but there were others. Over the next few weeks he also suffered from palpitations and, understandably, great mental anguish.

A specialist was called, Dr Robert Bree, who was an expert on asthma and although he dismissed the lungs as a source of the illness he did at least make Keats feel better by his reassurances and by prescribing a good diet and wine, instead of starvation which had previously been recommended. Slowly his health improved, and in due course he was out and about but in June he coughed up blood again. This time he was seen by Dr George Darling, on the advice of his friend Benjamin Haydon, the painter. Darling knew the true diagnosis and urged more of the blood letting already undertaken by Dr Rodd. By early July another consultant, recommended by Shelley, Dr William Lambe, agreed with Darling that the only hope was for Keats to spend the winter in Italy and plans were begun for him to go to Rome.

This required considerable preparation, and a companion had to be found to accompany Keats. Joseph Severn, a young and talented painter, who had known Keats for several years agreed to go. Taylor, Keats' publisher knew of a good doctor in Rome, James Clark, and made an advance of money to provide for the journey and stay in Italy.

On 17 September Keats and Severn embarked on the Maria Crowther, a brig of 127 tons at Tower Dock. Accommodation for the long sea voyage to Naples was pitiful, consisting of a small cabin shared by Keats, Severn, Thomas Walsh the Master, and a middle aged lady Mrs Pidgeon. At Gravesend, Keats was amazed to see another passenger embark; a pretty 18 year old called Miss

Cotterell who, with her companion Mrs Pidgeon, occupied one half of the cabin while the three men, separated from them by a curtain, slept in the other half. It soon became apparent that Miss Cotterell was as ill as Keats, and for the same reason. She found conditions stifling and needed to have the portholes open to prevent her from fainting, but the cold air aggravated Keats cough and he preferred them to be closed.

Weather conditions were appalling. Strong winds, storms and heavy seas made the passengers very sick and seriously limited progress of the ship along the English Channel. They had to enter port, or calmer waters several times before conditions improved and a favourable wind allowed them to head for the west French coast. Keats and Miss Cotterell, to mention the healthy passengers, suffered greatly. But he, during this time, did his best to minister to Miss Cotterell, allowing him a rare opportunity to use his medical skills. There were more storms in the Bay of Biscay and the journey to Naples took 5 weeks. On arrival they were obliged to lie at anchor in the Bay of Naples for a further week, seeing out a six week quarantine period imposed on shipping from England by the Neapolitan authorities who had heard of an outbreak of typhus in London.

Keats spent his 25th birthday ashore in Naples where he and Severn were entertained by Miss Cotterell's brother Charles, a banker working in that city. On 7th November they set out for Rome, a distance of 140 miles; a journey which took a week. Severn walked most of the way so that Keats could be more comfortable in the small carriage, along the route he picked flowers for his sick companion, to cheer him up.

In Rome Dr James Clark had found them rooms in a house on the Pizza di Spagna, overlooking the square, the foundation and what are now known as the Spanish Steps. Clark's, own rooms were across the square and he was there to greet them when Keats and Severn arrived after their long journey.

Clark was the last of the other doctors whom Keats encountered. His portrait hangs in the Royal College of Physicians. He was then a tall handsome Scot of 32 who had graduated at Edinburgh and for some years had been a Naval Surgeon. Now he had a thriving practice in Rome where there were many British residents and visitors. Later he returned to Britain, practising in London where he became very successful. He had an excellent manner and specialised in the effects of climate on disease, taking great care to advise the best possible conditions for their various illness. He moved into aristocratic circles and

became the personal physician to Queen Victoria and the Prince Consort, travelling with them on their journeys around England and Scotland. His popularity depended a good deal upon his attentive bedside manner but he was held in high esteem by most of his colleagues and all his patients.

Keats was very lucky in the choice of his doctor. There was no effective treatment for tuberculosis, so patients care depended on doing least harm and receiving sympathetic attention. Clark was conscientious and extremely kind, visiting Keats two or three times a day and helped by his wife who was also very attentive. Unfortunately Clark's diagnostic powers did not match his bedside zeal. By now Keats was hoarse, through tuberculous laryngitis, and had begun to lose his appetite and suffer abdominal discomfort, presumably because of spread of the disease to the intestine. Clark seemed to ignore his lungs (by now severely affected), pronouncing them healthy, and concentrating on the gastro-intestinal symptoms and obvious mental anguish. The inevitable venesections continued, but Clark believed in a good diet and fresh air. Keats actually rallied for a while in the Roman climate and congenial atmosphere. He took some walks and started to eat a little after settling difficulties with a local trattoria which initially provided him with cold, inedible food. But the improvement did not last. The haemoptyses returned (followed by more blood letting) and he declined steadily.

During the long miserable weeks that followed, Dr Clark and his wife continued their visits, but the hero of this last terrible chapter of Keats life was Severn. Joseph Severn was only two years older than Keats and can have little experience of looking after a very sick person. Dr Clark on meeting him decided that he was an unsuitable companion but he, more than anyone, tried desperately to relieve Keats anguish and depression. He attended to all his needs, read to him, played the piano, talked and listened. With no thought to his own comfort he was there day and night responding to every request of his friend. No man could have had a more loyal or devoted companion.

Eventually the end came. Keats died in Severn's arms on 23 February. He was 25. He died believing he was capable of becoming a great poet but thinking that he had failed: that the world had not recognised his talent. He insisted that on his gravestone should be the words: 'Here lies one whose name was writ in water'.

He is buried in the Protestant Cemetery in Rome, in a simple grave surrounded by a carpet of wild strawberries. It is difficult to imagine a more beautiful or peaceful place.

During his last illness Keats was very concerned about Severn saying: 'Severn I bequeath to you all the joy and prosperity I never had. It would be second death to me if I knew that your goodness now was your loss hereafter'.(2)

Happily and amazingly Severn escaped infection by the tubercle bacillus. He lived into his eighties and in 1861 returned to Rome, from England, to be a successful British Consul. He died in Rome and his body now lies next to Keats. On his gravestone is the inscription:

To the Memory of
Joseph Severn
Devoted Friend and Deathbed Companion
of John Keats
Whom he lived to see numbered among
the Immortal Poets of England.

R K Knight

(1) Antony Cox. Professor of Child and Adolescent Psychiatry UMDS (personal communication).

(2) John Keats and Joseph Severn: The Tragedy of the last Illness. Brock, the Keats-Shelly Association (1971).

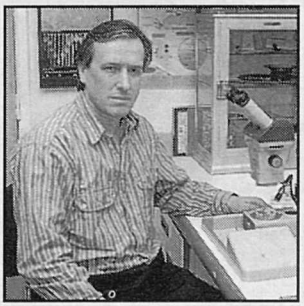
The information upon which this article is based comes from many sources acquired over several years but principally John Keats by Robert Gittings and the Biographical History of Guy's Hospital by Wilks and Bettamy.

JOHN KEATS
BORN
OCTOBER 29TH 1795
DIED
FEBRUARY 23RD
1821.
Ah! whereforo all this wormy
Circumstance?
Why linger at the yawning tomb so long?
O for the gentleness of old Romance.
The simple plaining of a minstrel's song!"
Isabella.

O Solitude! if I must with thee dwell,
Let it not be among the jumbled heap
Of murky buildings; climb with me the steep,-
Nature's observatory-whence the dell,
Its flowery slopes, its river's crystal swell,
May seem a span; Let me thy vigils keep
'Mongst boughs pavillion'd from the fox-glove bell.
But though I'll gladly trace these scenes with thee,
Yet the sweet converse of an innocent mind,
Whose words are images of thoughts refin'd,
Is my soul's pleasure; and it sure must be
Almost the highest bliss of human-kind,
When to thy haunts two kindred spirits flee.

John Keats

An Interview with Professor Andrew Lumsden, FRS



Motorbikes and Microscopes

Professor Lumsden is Head of Developmental Neurobiology at UMDS, the Sub Dean for Research, and the first person at UMDS to receive the Fellowship of the Royal Society, one of the highest accolades that a scientist can hope to achieve.

From the age of 15, Andrew Lumsden decided that he would like to become a research biologist, a desire cultivated from his interest in natural history and taxonomy. In fact, his ambition was so strong that he managed to convince his school to let him study botany and zoology at A-level, subjects that were not available and so he was allowed to teach himself. He also studied chemistry and attained grades sufficient to obtain a place at Cambridge to study biology and biochemistry. However, the latter was not to his liking so in his second year, despite being awarded a scholarship at the end of his first year, he studied geology in its place and then, in the third year, specialised in developmental and evolutionary biology.

What did you do after leaving University?

I was given a choice of working for my PhD in the Zoology Department at Cambridge to work in developmental biology or going to Yale University to work in evolutionary biology. At that time, Yale had the most impressive collection of evolutionary biologists and so I chose to go there; I was lucky to be awarded a Fulbright Scholarship to do so and, as it turned out, the journey over to the States (on board the old Queen Elizabeth - a condition of the

scholarship) was the highlight of the whole trip. Although fascinating to the amateur, studying palaeontology at graduate level, as I soon discovered, is ultimately frustrating because all you can do is tell stories about possible phylogenies - you can't do experiments and you can't even falsify hypotheses. It's basically just stamp collecting. So before very long I decided to abandon my graduate studies and said goodbye to any sort of academic future - or so I thought at the time.

How did you become associated with Guy's?

Whilst I was at Yale, in 1968-70, I was asked to take the department truck down to New York to meet a visiting scientist from England, Jeff Osborn, who at that time I did not know, but later found out that he was Professor of Dental Anatomy at Guy's. On the way from the airport back to Yale, with the aid of a bottle of whisky, we had a great conversation (mainly about pterodactyls and fossil teeth) and found that we shared many common interests, so I spent a lot of time with him whilst he was visiting. We then parted company and it was not until I returned to England, after travelling all over the States and meeting my future wife, that we were re-united. I had applied for a post, advertised in the Times, as a junior lecturer in dental anatomy at Guy's and came for an interview - only to find Jeff as the interviewer. It was clear that I must have made some sort of impression on him because I got the job and went on to study the development of teeth for my PhD. At this time, there was little or no molecular biology and our knowledge of tooth embryology was vague at best. I investigated tissue interactions in the facial processes of the early embryo and found that tooth mesenchyme is derived from neural crest cells. It was this, and Jeffs tutelage, that really got me hooked on the experimental side of developmental biology. Later, researching the innervation of tooth germs, I found a path that led me to my present interest in developmental neurobiology. In 1981 my work was aided by an extraordinarily enthusiastic PhD student, Alun Davies, who is now Professor of Neurobiology at St Andrews . It was during this time that we found a rich source of a chemoattractant in the embryonic face, whose existence had previously only been hypothesised, and managed to show its effect on guiding growth cone migration towards future target structures. This was the discovery that established Alun and I as 'names' in the field of neurobiology.

When did you move over to the Anatomy Department?

In the late 1980s, after Guy's and St. Thomas' merged, the school had funds and sufficient space to enable us to move to newly equipped laboratories. Once the group got going, our research really took off and we soon had publications in many of the top journals, including Development and Nature. Since 1991, the group has been funded by a programme grant from the MRC, a 5 year scholarship from the Howard Hughes Medical Institute in the States, and by project grants from the Wellcome Trust.

What are you currently working on?

The aim of our research is to understand the cellular and molecular mechanisms that direct the earliest events in brain development, determining how different brain regions acquire their identity and their specific repertoire and spatial arrangement of neuronal types. We study these events in the hindbrain, a region whose structure and function vary comparatively little across vertebrate species but whose early developmental stages are most readily accessible in the large and manipulable embryo of the chicken. Our initial studies, back in the late 80s, revealed that the hindbrain has a segmented organisation; pattern is set up in segmental units, repeated down the anteroposterior axis, that later coalesce to produce the overall plan of the region. This finding offered the promise that even the most complex of cellular patterns may be built up of simpler, modular units whose development may thus be more readily understood. Partition of the embryonic hindbrain occurs through the allocation of cell blocks (rhombomeres) between which cells do not mix and within which specific neuronal populations subsequently develop. The interfaces between rhombomeres spatially limit the expression domains of a number of developmental control genes including those of the Hox homeobox gene clusters. Analogous to the compartments of insects, rhombomeres are polyclonal lineage restriction units, with genetic definition, that act as the primary units within which regional specification is controlled. Our aim is to understand the molecular genetic basis of these early events that set out the 'ground pattern' of the hindbrain.

What are your ultimate research goals?

I suppose my ultimate goal is to establish how the embryo achieves the enormous feat of developing such a complex structure as the nervous system. I probably will never reach this goal, but we are acquiring new clues almost every day. On a more immediate time scale, we will be investigating how the anteroposterior axis of the embryo is established, specifically by investigating the role of retinoic acid on determining whether cells will develop into posterior or anterior structures.

Can you explain the process involved in awarding an FRS?

You are nominated by two Fellows, and then seconded by several others. Your name is then put on the nomination list along with whoever else is being nominated at the same time, which can be hundreds of people since the Royal Society includes all the divisions of science. A committee then examines your research activity in great detail and makes a decision as whether to accept you or not. The main criterion for the award is that your work be deemed to be a significant advance in your particular field of science. The most nerve wracking part of it was the public ceremony when having to sign the register - an ancient vellum book that contains the signatures of every Fellow since the Society began - with a scratchy quill pen that threathened to spray ink everywhere. So nervous was I that the signature I deposited is completely unrecognisable.

How did you feel when you were awarded the FRS?

It gave me enormous pleasure, mainly because it was so unexpected and because the main reward in science, in addition to discovering truth, is recognition by others. The FRS is the ultimate recognition of one's work. Personally, it also gives me a sense of immunity in every day work, a seal of approval. It can also act as a barrier, however, as many see it as an elitist club. It must be said that the Royal Society is not just a vehicle for individual recognition, but is also as an important force in fostering science, which is sadly rather under-promoted in this country.

As Sub Dean for research, do you co-ordinate research at UMDS as a whole?

No, there was an early suggestion to do this but it was soon realised that this would be impossible and researchers should be allowed as much freedom as possible. My role is more to do with helping Frank Walsh, the Research Dean, and with setting up a graduate programme at UMDS that is coordinated across departments. We are also revamping our research days into more specialised affairs. Formerly, everyone in UMDS was invited to display their work in a poster format, but this was largely unsuccessful, and so we decided to pursue a more specialised format. The first of the new type research days, on November 1st, will concentrate on developmental neurobiology. We have invited some of the world leaders in this field to lecture on different exciting areas of current interest - setting the work being done at UMDS in an international context. Next year we'll choose a quite different topic.

How do you see the merger with Kings' affecting research at UMDS?

Basically, there will be a lot more space available on this site, with transfer of some clinical research to Phillip Harris House. The merger with Kings' bio-medical sciences will result in a truly world class team of scientists in many disciplines. This should improve our working environment and also, perhaps more importantly, attract more top scientists to the combined school.

Where do you see yourself in 10 years time?

I hope still to be alive and well and working at Guy's. In fact, I have just turned down a rather seductive offer. However, even when one gets an attractive offer, which can be very flattering, UMDS is still very hard to beat as a workplace.

If you could go back to when you were a student, what would you have done differently?

I definitely made a few mistakes and lost about 6 years along the way, but I think this allowed me to have a very independent or even maverick outlook and also to be able to pursue several avenues. For example, I am very keen on motorcycles, which I used to race on the track when I was in America and for a while after I returned. I had to give up circuit racing in 1975, however, as I began to think about other things whilst I was racing, which is obviously life threatening and the cost of entering the races as a private competitor soon became too expensive. I think in total, I've owned more than 40 bikes over the

years. I feel I've had a wide and rich experience of life and wouldn't want to have done it any differently - but how it has turned owes much to chance.

What pastimes do you have now?

I enjoy engineering, which I learnt at N. Kensington night school so that I could build my own racing motor bikes, and I have a pretty comprehensive machine shop at home, which unfortunately is now lying virtually idle, owing to ever increasing demands on my time. But I do design and make equipment and instruments for the lab, including a device that enables you to operate a microscope with your feet, leaving your hands free to manipulate or dissect, and a pressure injection apparatus, both of which are now available from companies.

If you could meet any one person, who would you most like to meet?

I think it would be Darwin. He had profound insight into the organisation of the biosphere during a time that was intensely religious and preferred to let everything be explained by the fact that 'God did it all' rather than to consider deeper levels of causation. It must have taken great courage for him to reveal his thoughts and findings, as his views wreaked havoc with the beliefs of that time. I would have liked to see the natural world through his eyes.

So what are your views concerning the origins of the human race?

I am convinced that the origin of the human race was serendipitous and, as such, I am a firm believer of the 'chemical soup' hypothesis which postulates the chance meeting of molecules of increasing complexity and the acquisition of shape-dependent properties. I would have liked to investigate this professionally, but, unfortunately, I was not a good enough chemist!

Finally, how would you describe, in a nutshell, your work?

Fun and very rewarding, mainly because UMDS provides such a supportive environment. I have a great group of people working in my lab - 17 in total (including 4 PhD students, 10 post-docs), as well as benefitting from interactions with people in other labs. Doing science is in many ways its own reward; it is exploration and discovery, seeing what no one has seen before.

Paul Hayden

WHAT SHALL WE DO ABOUT TEXTBOOKS?

The Essential Freshers' Guide

There is nothing I like more than giving advice. I do it all the time, that is when I am not complaining that nobody is listening to me. I usually give advice without prompting, on a completely voluntary basis and totally uninvited. This time I have actually been asked by students to advise them, which can only mean one of two things:

i. students have actually, at last, realised that I have something to say (oh yes, sure)

ii. I have reached that certain age, generally known as 'past it', when it is believed by the young that one cannot do but can only talk about.

The third possibility, that there was spare capacity in the Gazette to be filled at very short notice, is too sordid to contemplate.

Take my advice then, since you asked for it. Why should you? There are advantages and disadvantages. Among the advantages will be the delay in the establishment of mutual death wishes between you and your bank manager and the fact that when you go home for the week-end there will be more spare capacity in your bags for useful things such as the washing rather than heavy printed material, at least for a while. The disadvantage of listening to me is also considerable: you will lose the exquisite pleasure of having made your own mistakes and of looking back and saying 'if only...', both of which are fundamental human rights which should not be violated.

My advice can be summarised in five detestable imperatives:

i. wait
ii. resist temptation
iii. supress all impulse
iv. exercise caution

and here comes the most hateful of all,

v. listen to your elders.

I thought it would spoil your fun. Now let me explain. It is an exceedingly satisfying sensation to fill your shelves with new books, straightaway, and tick them off the reading lists that the various course organisers, including myself, provide you with in their wisdom. Every tick is a little reassurance, here is all the information, all the knowledge, at your fingertips. And there is a grave danger that there it will remain, at your fingertips, without ever making contact with your eyes, not to mention other nether regions of your head. Resist the temptation. This is very difficult advice for me to give to anyone because my natural inclination is to give in to temptation be it books or chocolates or all sorts of other things, but you asked me for advice, not I. So, just you listen and never mind what I do. Exercise caution and discretion. Do not buy any books until the courses are well under way. No, I did not say do not look at any books. Everybody will give you advice, but to be on the safe side, you should only heed mine. The advice of second year students, for example, can be particularly dangerous, and not only on books.

The most important thing to bear in mind is that there is no one perfect book that covers any one course that we offer here. Some books are excellent in some areas and not in others. Other books are extremely good but may contain an amount of information excessive to your present requirements. Unless you are wonderful at ploughing your way through unknown fields and weeding out what is not strictly necessary, you will not be able to see the wood for the trees (rather a lot of agriculture here, sorry).

Other books are simple, easy and good for revision, but inadequate as textbooks and may give you a false sense of security. So, listen to your elders. This select group includes by definition all course organisers and tutors. Go to the library very early on. Find the recommended textbooks. Look up the learning objectives for various lectures and try to see how well they are covered in different books. And do not forget your lecture notes. This is the catch now, as unfortunately this implies attending lectures and tutorials and other teaching horrors. (Remember, you are not here only to have fun and enjoy yourselves and make friends and keep us in employment - although all of the above are noble aims.) Use your lecture notes as guidelines and supplement them with extra reading. This is why we give lectures, not simply to keep you off the streets or to prevent you doing things that you might prefer. Your textbooks should cover the material covered in your lectures at a reasonable level as prescribed by your lecturers and tutors. Also, look at past examination papers

fairly early on and see how these topics are dealt with in the book that you think you might like to buy. You will slowly get an idea of which books suit you best. Now go to the book shop. And, having got the books, use them.

Are you still reading? Congratulations on your endurance because I am now going to give you my opinion on 'which books' may actually be of practical significance. You could have skipped all the above, but you did not know that, did you?

The books I am going to talk to you about are listed in your course booklets in detail, that is, all authors with all initials and dates and publishers and editions, so here I will refer to them using abbreviated expressions, assuming that you will look up the rest of the information in the appropriate place. And check that you get the new editions, if possible, of anything mentioned. I shall not go through all the books listed in your course booklets, but I will give you my personal opinion on the ones that deal with the basic material. My personal opinion, may I add, is worse than useless on many topics, so you may be pleased to hear that I have taken the trouble to talk to a few other people before speaking with great authority.

In the beginning there was Clinical Anatomy of the Various Parts. I do not dare voice an opinion. You just do what they tell you, and buy what they tell you. Snell, I believe, is too big, but the Oxford series is recommended.

Then there was Biometry and Medical Statistics. Either Bland's Introduction to Medical Statistics or Kirkwood's Essentials of Medical Statistics are fine. Make your choice.

For Cellular and Molecular Biology, the best and most comprehensive is Alberts, but it is big and heavy on the chest if you read in bed, and contains information excessive to your present requirements. It is however good for supplementing Goodman's Medical Cell Biology (Lippincott) which is easy and basic but it will not cover all the topics adequately. Then, you need Histology- A Text and Atlas, which will be useful throughout the year for other courses as well.

Champe's Biochemistry (Lippincott) is a good introductory book, small and concise, but needs further support. It is also recommended for Human Metabolism with the same reservations. It is generally regarded with the utmost respect by medical students, because it lends itself beautifully to last minute study, a despicable habit practised by 99.9% of students, the other 0.1% being grossly abnormal. Last minute revision, is, in fact fine, as long as it is revision

and not sight reading the night before the exams. Harper's Biochemistry is more informative and Devlin's Biochemistry with Clinical Correlations is good and useful for the Gastrointestinal and Renal course as well. Wills' Biochemical Basis of Medicine will be improved in the next edition to contain material relevant to a lot of topics covered in the BMS course, so wait. Garrow and James' Human Nutrition is comprehensive but contains a lot more than core material. Use it in the Library.

For your Respiratory System get either Widdicombe's Respiratory Physiology or West's Respiratory Physiology- the Essentials. Levick is the ideal book for your Cardiovascular System and what it covers it covers well, but it is deeper than needed and big.

Rang's Pharmacology is an excellent all-embracing book for Pharmacology (what else?) and has good summary sections. Neal's Pharmacology at a Glance is good for revision but will not do as the sole book as it does not cover all the material covered in the course. Robinson's MCQ in Pharmacology is good for testing yourselves. Katzunt's Basic and Clinical Pharmacology covers a lot of clinical material not encountered in the BMS course, but will be useful later on. Beware, it is American and some drug names will be foreign! Berne and Levy's Physiology will be useful for the Musculoskeletal System and the physiological aspects of other courses as well.

For the Gastrointestinal system use Digestive System Physiology, and for the Renal system, the classic book is Lote's Principles of Renal Physiology. Sullivan's Physiology of the Kidney is fine but longer.

What have I missed? Quite a lot I suppose but I think that is enough for the moment. And we will still be here for consultation and reprimand. My God, this is terrible, I feel so old and wise, I must stop.

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PSYCHIATRY AT A GLANCE

At a Glance Series

C L E Katona & M M Robertson

80 pages, 35 illustrations, paperback, 1995, 0-86542-873-5, £9.95

This much needed psychiatric textbook is intended to encapsulate the student with all he/she needs to know with the aid of tables and diagrams; the text supplements this sufficiently to provide enough for a student to do well. It is fully authored by experienced teachers and examiners, with great portability and ideal for revision purposes.

LECTURE NOTES ON ORTHOPAEDICS & FRACTURES 3E

Lecture Notes Series

Professor T Duckworth

448 pages, 222 illustrations, paperback, 1995, 0-632-02781-9, £15.95

This text will appeal to any medical student, junior doctor or allied health professional who wants a core introduction to this important speciality. It has been completely rewritten to reflect the changes in the speciality and is now extensively illustrated in colour. The text is more punchy and boxed information has been highlighted for easier access. The sections on trauma, in particular, have been expanded.

LECTURE NOTES ON MOLECULAR MEDICINE

Lecture Notes Series

John R Bradley, David Rubenstein & David R Johnson

176 pages, 92 illustrations, paperback, 1995, 0-632-03851-9, £12.95

Aims to give the reader a concise and very simple introduction to how molecular biology works, and how it can be used to understand and treat human disease. It decodes jargon, explains the basic science and the practical techniques, and shows how the technology has already had an affect on clinical practice. The book introduces the basics of molecular biology, the practical techniques and how these have been applied to understand disease processes.

ESSENTIAL REPRODUCTION 4E

Essentials Series

M J Johnson & B J Everitt

280 pages, 199 illustrations, paperback, 1995, 0-632-03525-0, £19.50

This book provides a completely integrated approach to the study of mammalian reproduction, spanning the disciplines of anatomy, physiology, endocrinology, immunology, genetics, and obstetrics and gynaecology. It draws out the general, fundamental points common to reproduction in most mammalian species. However, it does not ignore the differences between species in some areas, often pointing these out in tabular form or as an illustration for clarity of presentation.

THE BIOLOGY OF DISEASE

J D Phillips, P G Murray & J Crocker

320 pages, 115 illustrations, paperback, 1995, 0-632-03855-1, £16.95

This is an introductory level text on the biological principles of human disease. It brings together material which is conventionally dealt with by several books. The authors have covered the fundamentals of each topic in a readable manner, which should encourage students to develop a fuller understanding.

'Struck Off and Die'

The George Inn, Friday 22nd September 1995

The last time we heard from one of Guy's Hospital's most famous graduates, Tony Gardener, was back in July, 1993 when he was interviewed by the gazette in the rather noisy and sordid surrounds of the student bar. For the benefit of the freshers and any other ignorant library dwellers, Dr Tony Gardner and his partner in crime, Dr Phil Hammond have become a huge success as the infamous and outrageous comedy duo 'Struck Off and Die'. As luck would have it, Kate Mundray and John Davies from the gazette managed to bump into Tony in The George Inn and on the off chance happened to have a few searching questions ready to ask.

Kate Mundray: Could you remind us of how Phil Hammond and yourself both met and formed 'Struck Off and Die'?

Tony Gardner: For the benefit of those who didn't read the interview in the Gazette 2 years ago, we met as house officers in Bristol in 1987 and we put on a Christmas show together. A couple of years later Phil phoned me up and said he was doing some medical stand up, giving us the idea of starting up a double act which we took to the Edinburgh Festival in 1990. On the back of this we gained a lot of press through being the only people having done this sort of medical act. The act was very controversial as we had a go at the medical profession and told the press that we were about to be struck off which, of course, was totally untrue. To increase our appeal we advertised on our posters quotes from the GMC saying that they thought we were disgraceful, when they had never even heard of us. From this we managed to land a radio series and now we have just completed our 5th Edinburgh last month.

John Davies: What did you hope to achieve? Was it purely a bit of fun or did it have some sort of political basis?

TG: Fame and fortune first of all, of course! No but really, we both liked performing on stage; there's always an exhibitionist desire. I think initially, as we were both junior doctors we did think we would be able to change things

and draw attention to certain aspects of being a junior doctor that we didn't like. Then we mellowed out a bit, realising that there was nothing we could change without the support of other junior doctors, who as you know are a notoriously apolitical bunch. This year's show was far more political than we have been for a while, but first and foremost you have to make people laugh and then you can stick the knife in. We still do care very deeply about the NHS and about the problems of junior doctors despite not working as one any more. Some people criticise us saying that we undermine the profession and how wonderful it is to be a doctor, but we are not, we're doing it because we want to publicise the problems within the NHS.

KM: What have 'Struck Off and Die' been doing since we last spoke to you in Guy's Bar in July 1993?

TG: We did Edinburgh that year with our 'Best of' show for which we won the 'Pick of the Fringe' award, after which we did a season in London. Last year we took half a year off as we were getting bored and both our wives were expecting. In August that year I qualified as a GP and I've been working as an actor ever since, so I haven't been practising any medicine now for a couple of years. We both struggled for 'bit' parts in various things, as most actors do. I did a load of McDonalds adverts (the one with the 50p pieces!!??) which kept the money rolling in. We went to Edinburgh this year with a brand new show and did very well. I thought it was our best show ever and we are going to tour it next year around the country at some larger venues. But first, we are going to be performing it in London from now until Christmas (plug plug!!) In the mean while, Phil and I are supposed to be writing a new radio series (the first series won the 'Writers Guild Award' and the 'Sony silver award' for the best radio comedy series). Also in the pipeline is pilot for Channel Four, which will be a sort of spoof 'hospital watch' documentary.

JD: As your humour is based around the medical profession, do you feel that you have a large general public audience or do you just cater for those who are in the profession itself?

TG: The only time we perform to non-medical people, apart from next year's tour of the country, is at Edinburgh. I always think that half of our audience are doctors, nurses and other healthcare workers. The other half have almost definitely been to a doctor at some point in their lives and therefore have

experience of the medical profession, so I don't think the show alienates the general public. We try to write shows from a point of view that can be understood by anyone, we are not trying to cater just for doctors at all, we try to cater for everyone. In fact we are just trying to be funny.

KM: The media and the general public seem to have a fascination with the medical profession at the moment, there are an amazing number of TV shows based around it. Do you feel it is just one of those phases, a few years ago it was lawyers and now it is the doctors' turn?

TG: From an actors point of view you can't cast for anything at the moment in drama, unless it is about being a doctor or a policeman. I think it is very sad and it's just a phase that people are going through. It just makes for good viewing figures but I'm sure it will pass. This 'phase' is probably why as 'Struck Off and Die' we have become minor celebrities. It will be interesting to see what happens in the next few years what with the health reforms and everything. It seems that the public are becoming less and less patient with doctors and there problems and they are beginning to get fed up with it. They feel, rightly so, that they have a right to choose and criticise their own doctor; maybe this attitude will end the fascination with the medical profession and reduce the number of medical TV dramas.

JD: If you had your time over again do you really think that you would choose medicine as a career?

TG: Good question, I have asked myself this question many times. Well, many studies have shown that fifty to sixty percent of junior doctors who were asked this question say 'no' they wouldn't do medicine again and I think that statistic stinks. But it is a very important statistic bearing in mind the money that is spent, the hassle they have to go through to get into medical school and the work they have to put in, when at the end of the day when they qualify as a doctor, a large percent wish they hadn't done it. Something has got to be going wrong somewhere. These type of statistics are not shown in Australia, the States or even Ireland where they have decent working conditions, so it seems to be a reflection of the working conditions rather than the job itself. Coming back to would I do medicine again, I can't really answer that question. I definitely had a true vocation to be a doctor from about the age of seven or eight and I was glad that I qualified as a one. I also really enjoyed General

Practice, it was a good job, but I've just happened to find something which, for the time being, I'd rather do instead and I'm having a great time doing it. I will probably go back into medicine one day. On the other hand if I hadn't done medicine I probably wouldn't be at the stage I am now, a comedy writer and performer. I've been very lucky. It's a difficult question to answer whether I would do medicine given the chance again, yes is the answer I presume.....or maybe no?!

KM: The average doctor produced from Guy's these days is very different to the one that you portray in your shows. Do you feel that the attitudes within the medical profession are changing in that it is becoming less sexist, classist and racist?

TG: As I said before, there is no point in portraying reality in a comedy show; you have to take it to the extremes. Comedy is all about taking small aspects of certain things and blowing them up into ridiculous proportions. Having said that I see the type of doctors we portray still coming to see our shows today. So they do exist and they are haven't changed their attitudes in the slightest. I'm not saying that they make bad doctors, maybe they do, all that we are doing is just portraying particular types of medical students and doctors. No, I don't think the attitudes are changing, and until I see that fifty percent of consultant surgeons are women I will continue to say that the doctors of today are exactly the same as when I was a medical student.

JD: The medical course at Guy's has changed quite a lot since you were here, as we now take final exams throughout the whole clinical course and there is a further thought that it might change to become similar to the American System whereby you need to complete a pre-medical degree before entering medicine. Do you think that this will make junior doctors 'older and wiser' or do you feel that aged 23/24 is old enough?

TG: Taking final exams over three years sounds awful. It may be a good thing, I don't know, I'm only speaking from a personal point of view. I had a fantastic time at Guy's, but the first year was horrible. Well that's not entirely true, it was good, but then you had to take exams. In years three, four and five I did absolutely nothing. I used to go down to the bar at five o'clock and drink seven pints by seven or six by six or whatever we were doing that week. Then

you go on elective have a really nice holiday and you'd know that when you come back in January you would have to slog your guts out for two to three months and hopefully pass your exams in the summer. Nowadays it seems as if you have to do your finals by the end of Freshers' Week. About the American System, I use to think that was the way forward, but after speaking to a lot of doctors who qualified in North America I realised that they have the same problems over there. What more of life are you going to learn by spending an extra three years at university stuck in a library learning about English or History. I don't know, it may possibly help as I do think 23 is too young to be a doctor. One wonders whether it would be better to send people off for a year travelling round the world, as that's when you learn about life.

KM: What was the best thing and the worse thing you did when you were at Guy's?

TG: The best thing was when I became Footballer of the Year in 1984-1985. I still have the trophy at home and I am immensely proud of that. I use to play in goal for the 1st XI for about three years. The worse thing I ever did was when I lost voluntary control of my anal sphincters at Hither Green Station on my nineteenth birthday!

JD: Could you tell us a bit about the Spirochaetes? The first thing that springs to the mind of the average boring medical student having just done Pathology is Treponema Pallidum?

TG: The Spirochaetes is a way of life , an institution, an attitude. No seriously, Spirochaetes is something I got into in my third year at Guy's. We are supposed to play hockey but we don't. It has become more of an old boy's club now. It has been going since 1959 and out of the 25 people who went this year only three or four weren't qualified. We try to get two new people along every year just to keep the Guy's thing going. It is a really nice way of meeting up with people that you lose touch with; much better than trying to organise reunions. We all go down to the Pagniton Hockey Festival once a year at Easter. It is my 12th year this year and I can't even play hockey, I can't even stop the ball and I was captain one year. It's just a good excuse to get really drunk.

KM: How was Edinburgh this year? What did you get up to?

TG: We did a brand new show. We hadn't written any new material for three years so we thought it was about time. The new show is called 'Struck Off and Dies' Television Pilot'. The premise was that we were doing our own television pilot because no one else had ever asked us to do one. It was really good, we were at one of the bigger venues in Edinburgh and we were sold out every night. I also did a comedy play, 'Shelf Life' - my 'actor role'

JD: Could you tell us about your new recruit to 'Struck Off and Die'?

TG: Our new recruit is a guy called Tom Binns and he will be touring with us from now on. His main character is Ivan Brackenbury a flagship presenter for Chesterfield and North Derbyshire Hospital Radio. Ivan is meant to be the worlds' worst hospital DJ. He says things like 'I've had a message from John who is not very well at the moment, he's in a critical state on intensive care. He asked me to play Bohemian Rhapsody by Queen. Well, bit of a long record John not really much point'. He just tells all these terrible gags.

KM: As this interview will be printed in the October issue of the Gazette we will have a new intake of freshers. Do you have any 'words of wisdom' for them?

TG: Just enjoy yourself and play some sport, that made a world of difference for me at Guy's. Join some clubs, choose something that you really want to do. That's where you meet people, socialise and get involved!

Kate Mundray and John Davies

The Evolution Of The MCQ Book

The continuum of time has seen the evolution of all things, some more dramatically than others.Unfortunately there are always exceptions to the rule and evolution stops where the constants of medical school life begins. No, I refer not to the traditional white coat of doctors nor to the ignorance of preclinical students but instead, the quest to find a good MCQ revision book.

At the end of term when those vital exams loom ever nearer, and the overdraught facility is but pocket change, the fateful decision 'beer or books' finally rears its ugly head. Whilst the younger less experianced student might scowl in deep thought over this dilema, more seasoned veterans of the Guy's campaign will know that the secret to success lies in MCQ practice, and this will now top the priority list. Dead and buried are MCQ books with no explanation to the questions, for in this consumer-led society of beer drinking students, publishers are finally beginning to listen to our demands for cheap multisubject books. **MCQ'S IN CLINICAL PATHOLOGY (Saunders, ISBN 0702017825, £8.95)** fulfils this criteria magnificently.

This compact book is well presented and covers the range of subjects essential for pathology. It includes questions on histopathology haematology,microbiology and chemical pathology but the crucial subject of immunology seems to have been disregarded (the department must have been on holiday).

The book contains 300 questions,each of 5 parts and therefore in numerical terms represents good value for money.The questions are varied and wide ranging and the answers concise.This broad scope will allow easy testing of all the core subjects and provide some peace of mind, before those intimidating pathology exams.This book is a must for those sitting pathology and those students environmentally conscious will be pleased to know that the book is also printed on acid- free paper.

Balraj Singh Sidhu

THE WAY IT WAS

Since returning to Guy's - at a very part-time level - after a break, life has taken on some curious turns. One recent course I have attended was peopled almost entirely by midwives: a group in our profession I have probably had least to do with, until now. But this has led me on to further discussion about that part of our life I have written about least. I refer, of course, to birth; death has featured in this column on more than one occasion. Midwives are all to do with our arrival on this earthly scene, although in the past, before midwifery qualifications were taken up nationally, 'handywomen' not only assisted at the birth of babies, but were also called upon to lay out the dead. This is going back to the early days of the present century, but an interesting book which I've recently read, entitled 'The Midwife's Tale' (Scarlet Press) by Nicky Leap and Billie Hunter, outlines the transition that has taken place. This is a book of oral history. Midwives, mothers and others, have been interviewed and give some vivid descriptions of what it was like to be a midwife or a mother before the inception of the NHS in 1948. All this is well before my time! As compared with some dry history books, giving details about professional development, this book contains real life, and the experiences of those involved. Some of the stories almost make one hair's stand on end; on the other hand, many of the practices which are often described as sympathetic commonsense, makes one wonder about the wisdom of some 'hi-tec' hospital obstetric measures. Indeed the authors point out that there is a trend towards a return of commonsense practices, especially where the home-delivery of babies is concerned. Childbirth is a natural process, and the emphasis was on this in the days described in this book. Midwives had, and continue to have, a great deal of independent responsibility. In the past, basic facilities, such as rapid transport and telephones, left midwives delivering babies at home, which was the norm, very much to their own devices, and initiative. One midwife, working in rural Devon in the 1930s gives this description: 'When you were in some of the country areas you often had 30 miles to go to a consultant hospital. I think you had to know what you were doing then as much as you have to today - maybe even more so? We only had the odd case of haemorrhage and we did have ergometrine, which was a great thing. One case in particular I remember and that was a very severe haemorrhage. We hadn't, a doctor booked and the woman made a mistake. You see, it was difficult to get case histories always. Well, half of these things you didn't think about... What she failed to tell us was that, if ever she cut herself, she bled badly. You see, they didn't realise things and you had no idea... Well, I was five miles from a doctor and another two miles from a telephone. Anyway the husband

was very good and he went to the telephone, but unfortunately you had to rouse the post-office people. And they didn't want to get up! The doctor was mad about that. You had to do compression to stop the bleeding. The woman was all right afterwards and the baby was all right'. All a far cry from today, some 60 years later! The first Midwives Act came into force in 1902, in England & Wales, and 1916 in Scotland: this established a role for qualified midwives. But it was not until 1936 that another Act laid responsibility at the door of local authorities to provide a service of salaried midwives, and to set up a Midwives' Teaching Diploma. Apart from details about the care of mothers and babies, this book carries interesting sidelines on abortion, contraception and unmarried mothers: all topics regarded, both in practice and attitude, differently from today. There are a number of fascinating illustrations, one showing babies in cots, where a metal frame each held four suspended in a row, at Guy's in 1947. Before the NHS was set up to provide free care in 1948 most births were at home. That this was so is explained by a midwife working in our locality, Bermondsey: "...I was thinking of the reasons why people stayed at home. In the lower social group, they hadn't got night clothes and although hospitals issued them they didn't want it known. They also had communal washing things at home, one face flannel, one toothbrush, and they didn't want to show that one up either. They had to stay at home because husband would drink or gamble or bring another woman home, children wouldn't be fed, there was no home-help service, they wanted to go back to work". One interesting chapter deals with ignorance that existed surrounding the facts of life; one mother asserted, "we were all green surrounding the facts of life; one mother asserted, "we were all green". This reminds me of a Radio Four documentary, when nonagenerian women were interviewed. One commented, she had never heard of 'organisms' until reading about them in her grand-daughter's Cosmopolitan!

Denis Cobell.

Rugby

2nd XV 1994/95 Season Report

P	W	L	D	F	A
26	13	13	0	448	365

Hospital Cup Winners 1995

Following the success of the previous two 2nd XV captains to lead the side this year was both a daunting and inspiring task. It was made even harder coming in the wake of the 1993/94 sesqui-centenary season which was a huge success and drew support and commitment from all club members both on and off the field. The post celebration euphoria left the enthusiasm banks a touch dry; this manifested itself in a lack of consistency, with players changing frequently. Not once was there a settled side regularly playing together each week. However, a recognisable core did begin to emerge mid season, along with a small but talented crop of freshers who established themselves in the squad.

The early and middle part of the season brought mixed fortunes on the field with results up and down like whore's draws. Our most notable victories, however, came over Old Alleynians, 7-0, and Met Police III, 14-11. On both occasions we only managed to field 14 players, but the commitment from each player was awesome, the tackling was fierce and the communication in attack was sharp.

The biggest points win for us was 37-0 against H.A.C. 1st XV, but probably the most enjoyable venture was the excursion of both the Guy's 1st and 2nd teams to Gosport. The 2's had plenty of old hands to help conjure up a win over a 'superior' side. Scanners, Russell, Beardmore, Tank and Bates enjoyed their trip to the coast all contributing to a 16-7 win.

The highlight, and main goal for the 2nd XV is the Hospitals' Cup Competition. As current holders and having won the cup for the last 2 seasons, the pressure was on to retain the trophy for the 3rd year running. Amid the tension and rivalry Guy's were drawn against 'the other place' in the 2nd round. Propaganda flew suggesting that St. T's were much weaker and an easy prey, but we knew it would be a true battle royal. The elements were against us in the first half and we were pinned deep in our own 22. They scored first as their pack dominated and stole two pushover tries. The second half, however, was ours and Guy's eventually edged home 21-10 to the delight of the partisan Guy's support.

Charing Cross in the semi-final proved a lot easier than expected, but Guy's produced the outstanding performance of the season led by Marcus Sharp from the back row. There was wonderful home support and we romped to victory 28-6.

The final against St. Mary's was extremely hard with the boys leaving it very late in the second half, sending my

blood pressure through the roof. At 6-3 down with 15 minutes to go our forwards were pressurising Mary's line. A flash of genius from Murphy at No. 9 sent our blind side winger, Bill Shaeffer diving into the corner for a try. The touchline conversion from Gush forced Mary's to push for a try leading to a mistake which allowed Guy's to break from our 22 resulting in a scrum to us, just inside Mary's half. The dummy scissors at fly-half sent Ronan free through the centre and at the line he popped the ball up for Shaeffer once more to score in exactly the same spot. This sealed victory on a thrilling final, 15-6, and the cup was once again with The Oldest Rugby Club in the World. The crowd went wild, Mary's were scuppered and the celebrations began.

During the season certain players matured and helped the backbone of the squad. The players who showed great promise for the future included Matt Arastu, Jonny Spencer, and of course Barny Schofield. The usual outstanding performances were given by Angus, Ronan, Murphy and Ansell, whilst Nick Gibbons carved his own place in the side and scored undoubtedly the best individual try of the season. For me however, the most improved player and the 2nd XV player of the season was Marcus Sharp.

I'd like to thank all the boys for their support and commitment during my season as captain, particularly Marcus and Mark Ansell for exceptional loyalty and support, even when being dragged kicking and screaming into the 1st XV at the end of the season.

I've thoroughly enjoyed my captaincy, especially holding up the Hospitals' Cup for the third successive year (does that mean we keep it now?). Finally, I would like to wish Barny Schofield the best of luck as 2nd XV captain for the 1995/96 season.

P. Gush

UMDS Boat Club

U.H. Bumps

One of the biggest events in our year, the Hospital Bumps were raced during the beginning of May. All crews had been working hard for these and were keen to do well, especially the mens first VIII, looking to stay Head for another year, initially being chased by St. Mary's. A quick start at 46 saw us pull away from them on the first day, and we could afford to ease slightly as Charing Cross moved up to second, catching Mary's by Kew bridge. We managed to hold off Charing Cross on the following day, too, our superior start again giving us extra distance on the chasing crew, but not without a spirited fight from Charing Cross who closed to within half a length by the finish. Unfortunately, the third day saw us caught by The Cross. Once again, we had a better start, pulling out about half a length on our opponents, before settling to a rating of 37. Pushes at each of the bridges kept them at bay, but their superior size and "chopper" blades meant that we were caught in the last 500m of the race, after holding them off for over 10 minutes. Despite being bitterly disappointed, we knew we had been beaten by a better combination; would we still have been Head if we had had the regular use of "choppers"?

The mens second VIII had only been practising regularly for the past month or so, and were starting in position 11. The prospect of bumping up into the top 10 was encouragement enough for this crew, and after gaining on the Royal Free first boat each day, finally managed to find that little extra bit of speed for the bump, catching them just down from Kew bridge on Wednesday afternoon. This was quite an achievement, as for much of the season The Free's first VIII has given UMDS first VIII a close run for their money.

Our novice VIII had mixed fortunes racing in their first Bumps event. A fine row on Monday saw them catch the UCH novice crew, only for them to be caught back on the Tuesday, much further down the course. Any thoughts of bumping with UCH for a third day were scuppered when one of the blades came out of its gate, and they were quickly caught from behind. In contrast the ladies novice VIII were in fine form throughout the three days, bumping up each day to earn their blades, Charing Cross, St. George's, and St. Mary's being bumped down in the process. This was a fine result for a crew who has won every hospital and UL event when they have been racing in a competitive boat - long may it continue!

Monday's racing took part on 6th May, and this gave the ladies second VIII (a crew of ex-rowers) the chance to dress up to commemorate VE day, 50 years on. Decked out with Union Jacks and wearing "appropriate" costume (I wonder what it's like rowing with a bowler hat on?!) they held their position well, although they were caught on the subsequent days.

Our ladies first VIII had long been looking forward to the Bumps, to see if they could succeed where last years crew had not - to bump up into the top three. Rowing on a shorter course from the men meant that they had less time to make up the distance on St. Mary's in front of them. Good starts on all three days saw length gained, with their cox reporting that at one point on the last day they had wound the rating up to 50 (!), but Mary's also had powerful starts, and were able to keep clear water between both boats by the finish at UL boat house.

The Hospital Bumps is one of the biggest events that we are involved in, and this year all of the organisation has been carried out by Andy Hobkirk, UH Captain. Many thanks are due to him for much of his time and endeavour, as they are to Vice-Captains Richard Baird and Matt Gray, and President Gleeson for his support of the club and UH this year. Final thanks must also be extended to every member of UMDS Boat Club, who contributed to all of the UH events run this year by UMDS, and helped to make them a great success.

Steve Arnold

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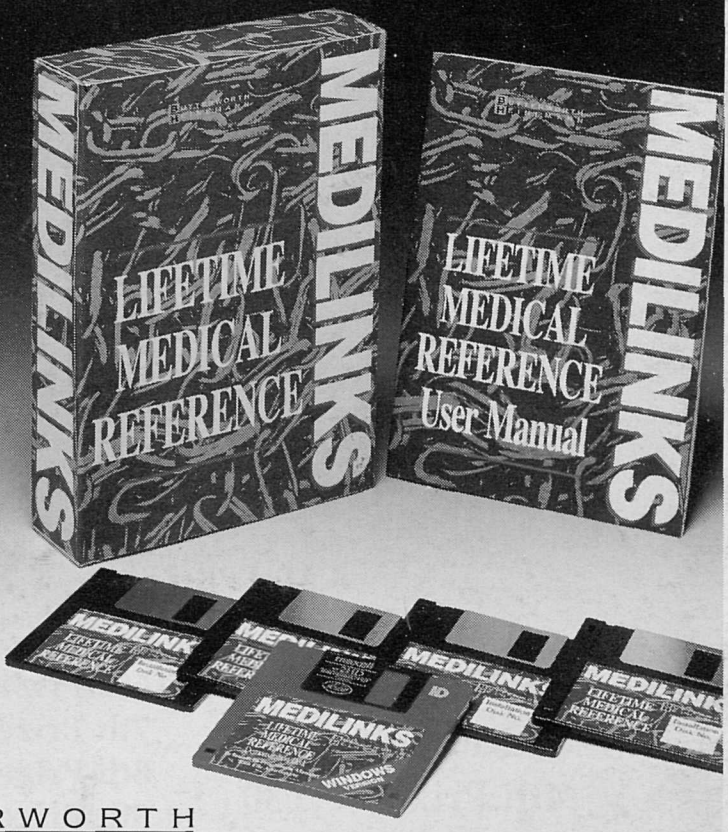

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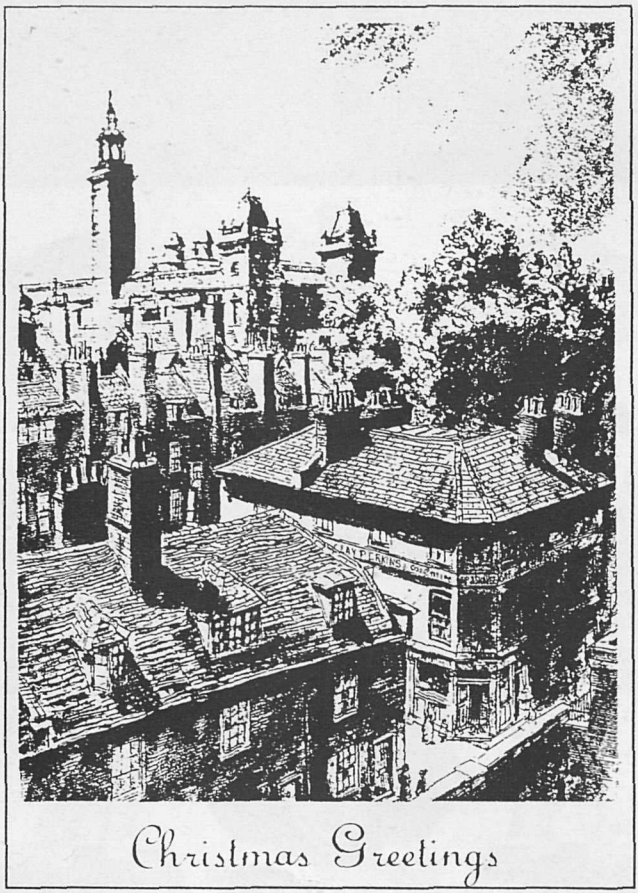

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Guy's Gazette

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Passim

As we approach the ending of another year, let us take this opportunity to look back at its important events.

Foremost of interest have been the developments in the campaign to save our great hospital. At the start of the year we achieved our first target of collecting a million signatures for the appeal with great ease; support for the campaign was increasing and public concern for the future of health care in London was growing. Then followed the reprieve to Guy's A & E with closure deferred until the end of 1998 at the earliest. This re-iterated the need for retaining acute medical services at the Guy's site and also demonstrated the value of continued campaigning and that we were not just fighting a lost battle.

A subsequent goal of the campaign strategy was to win enough support to seek a judicial review of the Secretary of State's decision. The case was heard at the Law Courts in London, just recently and although we were hopeful we were sadly denied the opportunity to appeal. Mr Justice Laws decided that the application had been made too late. It would appear that an earlier application may have been successful. No doubt, an earlier case would have been made were it not for the fact that certain sets of figures crucial to the case were not provided by the Trust. An odd reluctance to release data to those most concerned with their implications.

Alongside the changes in medical care equally concerning developments in medical education have been taking place. The proposed merger between UMDS and King's College is becoming increasingly imminent. The parliamentary bill to merge the two institutions approaches its reading in the House of Commons in the early part of the new year. The benefits of merger pertain to a more integrated learning environment, with the advantages of a background in a multi-faculty institution. However, any such merger serves to diminish the identity of our medical school as an excellent independent teaching and research facility and also of our great hospital as an exemplary teaching hospital.

The political uproar has been accompanied by mayhem of another kind. Construction or rather reconstruction has been taking place across the Guy's site, in an attempt to create an environment, more pleasing to the eye. The medical school had been hidden behind scaffolding for months, and the end result was a well polished exterior. However, the pleasing outside still does not prepare one for the lilac and blue interior. Guy's Tower reception has also had extensive remodelling both inside and out, with the interior design undoubtedly based on an airport departure lounge. Philip Harris House finally looks complete but we still await the opening and patient usage. Hopefully, the well publicised palm trees are being well nurtured in the interim.

Finally, as we approach what will probably be the sunniest festive season yet, on behalf of all at the Guy's Hospital Gazette, we extend very warm seasons greetings to all our readers and their families and wish them and our mother hospital a more fruitful coming year.

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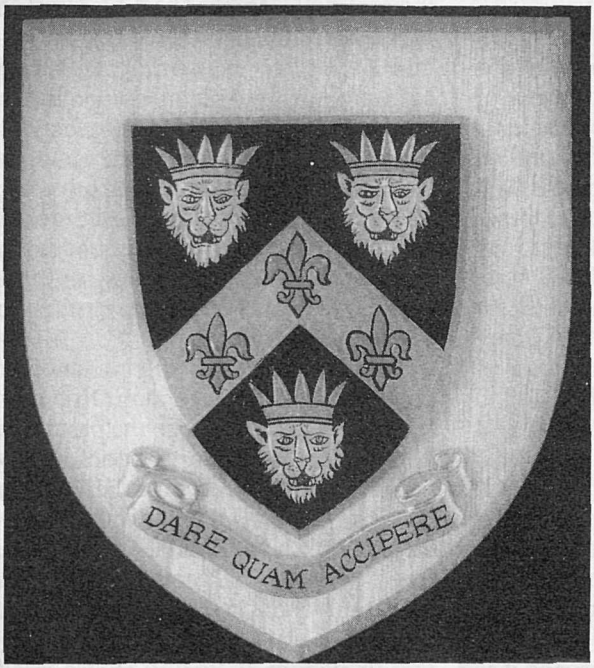

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Insecurity

Dear Sir,

I am writing concerning the appalling standard of hospital security which has failed to stem the steady flow of break-ins and other offences against the property of Guy's Hospital and its Medical School. Apart from the well known incident when the machinery housed in the boiler room of the tower was tampered with, there have been several other break-ins, the most recent of which involved computers being vandalised in several different floors of the tower. One appreciates that the job of securing a hospital as large as Guy's is a difficult task, but as a medical student who walks around the hospital most days of the week I can see what an easy time the thieves must have. The security guards, far from looking vigilant, seem very lethargic and lack-lustre. They are often too timid to ask any questions of anybody, or perhaps it is that they feel that the hospital is not in need of tight security. As for the Security Guard Firm who 'take care' of the medical school, it seems as if their main priority is to constantly hassle medical students usually in a very condescending manner. I personally do not mind being asked for ID every time I enter the Medical School, but I don't see the point when half the time the guards are sat in their 'cubby-hole' in the entrance to the building either watching television or having a cigarette, while half the world passes by. I also find it hard to comprehend, that so many bikes get stolen from the bicycle shed which is just outside the entrance to the Medical School. Why can't there be a guard on duty there at all times? I am always seeing children hanging around the bike shed, sticking out like sore thumbs but security never seem to do anything about it.

Boland House security is another problem. The Student Union Office has been broken into twice in the past three weeks. The Spit Dining Room hardly has any vending machines left which are operational as they have been ransacked . With McDonalds downstairs, there are always groups of youths hanging around, so you would think it sensible to have security guards patrolling the whole of Boland House at all times. I think it is about time that we reconsidered the current security measures and re-established a more secure environment for staff, patients, students, and property.

Yours faithfully,

A. Williams

United we stand?

Dear Sir,

I was deeply saddened to read the most recent news of Guy's in the september gazette. On the one hand, a poignant article by Professor Hughes on what should have happened to this great hospital. On the other, a complacent interview with Professor Chantler, apparently content with the demise of the hospital as we know it.

A house divided against itself cannot stand

Yours faithfully,

A S Horner

Nurses' Ball

The annual nurses' ball was held on Saturday 30th September at Grosvenor House, Park Lane. The ball was sponsored by Guy's Special Trustees and was once again a great success. The ball has become a highlight of the nursing year at Guy's and both students and staff of the trust are welcome. This year, the entertainment included dancing, a casino, and a raffle to raise funds for Guy's & St Thomas' Kidney Patients' Association and Ronald McDonald House.

Honoured

In Her Majesty's Birthday Honours list earlier this year, Professor W J Tulley was honoured with the award of OBE.

Professor Tulley was a past Dean of the Dental School at UMDS and the award was noted as being in recognition of his work for the disabled and especially the 'Dial-a-ride' scheme in Surrey. Professor Tulley is disabled himself and for many years has been going about the hospital in a wheelchair. We offer him many congratulations and wish him well in continuing this very charitable work.

Tragic Death

On the 26th September, a critically ill boy, a patient on the paediatric intensive care unit at Guy's, died during an unfortunate power loss which is said to have occurred as a result of a fault in the secondary power generators that support Guy's Tower. The press statement released afterwards stated that the death was not related to the power failure and although 20 patients had to be hand-ventilated during the 25 minute disruption, preliminary enquiries reported that no patients were adversely affected by the power failure. The statement also went on to say that the Trust has taken steps to ensure that this does not happen again by modifying the primary power supply and the stand-by generators.

John Fry Reunion Dinner

The John Fry Dinner was started in 1988 by the late Dr John Fry for his fellow students of the year 1944. It has now extended to include most of the 1940s.

The eighth of these dinners was held at Guy's on October 16th of this year and as always, proved most enjoyable. It was attended by 55 Guy's men, including a couple who had travelled from North America. Next year's dinner will be on Wednesday, October 16th, 1996 at Guy's. Any Guy's man who thinks that he might enjoy the company of old friends and fellow students should contact Dr R E Irvine, Dolphin House, Le Foulon, St Peter Port, Guernsey, GY1 1YY

Joint Committee

Professor Gwyn Williams has recently been appointed Chairman of the new Joint Guy's & St Thomas' Medical and Dental Advisory Commitee. Professor Gwyn Williams is a renal physician and Professor of Medicine at Guy's and prior to this new appointment, was a keen Group Clinical Director and a member of the Trust executive.

Clinical Day

Next year's Dental Society Clinical Day is to be held on Saturday 2nd March, 1996.

The programme starts at 09.30 with the Herbert Memorial Lecture, to be given by Professor Edwina Kidd, entitled 'In praise of G V Black'. The lecture is followed by a series of trade, staff, and alumni demonstrations covering many aspects of clinical dentistry and research. A treatment planning table clinic is included and visitors are invited to bring the records of cases that they would wish to discuss with consultants of the Unit of Restorative Dentistry. The final lecture, entitled 'Cases you have referred', is to be given by Mr Richard Haskall.

This major Guy's Dental alumni meeting is open to all dental surgeons and members of their teams. For further enquiries, please contact Mr L A Usiskin, Dental Sub-Dean, Medical School, Guy's Hospital.

FRESHERS WEEK 1995

Welcome to UMDS!

They heard the call, and from far and wide they came, some venturing forth for the first time, others returning to familiar territory. For FRESHER'S WEEK had begun and with it came the age old tradition of the hunters and the hunted.

Laurence Boss (Fresher) on his first day at Guy's

'I arrived at London Bridge station on the first Wednesday, eager to start my new life at Guy's and St Thomas's. I had the biggest grin that you could ever imagine, and then I saw Guy's tower. I heard the thud of my chin as it hit the pavement, how would I survive in this large place?

With the assistance of two other freshers who had arrived a week earlier for the biology course, I quickly found my room. Only thirty seconds later, I was invited in for coffee by a girl on my floor, who explained that this was the first time she had been sober all week. Freshers week hadn't even started yet!

'...I quickly found my room. Only thirty seconds later, I was invited in for coffee by a girl on my floor, who explained that this was the first time she had been sober all week. Freshers week hadn't even started yet!'

We headed off for the Cheese and Wine evening, where it seemed that everyone knew each other, all except me. But after a few glasses of wine people introduced themselves, everyone got talking and seemed friendly enough. Afterwards everyone headed up to the Tommies bar where it was announced that a pub crawl had been organised. Two freshers had to have their legs taped to a non-fresher. It was my misfortune to be taped to the guy who had organised the event. At the first three pubs we had to down the pints. At the fourth pub, and after another two pints, I unknowingly insulted a fourth year and the last thing I remember was him getting his cheque book out!

I awoke at four o'clock in the morning in the lounge at Tommies and staggered out to find a cab. I then had to wait until half past five to be let into Wolfson House. The next day I seemed to know so many people or at least they seemed to know me. My time at UMDS had officially begun.'

Schoolboys and Schoolgirls-(alias 'Teenagers and Hormones Hop')

Short skirts, wonderbras, cross-dressing, socks and tissue paper is the only way to describe this night. A bar night where all inhibitions were lifted and many people laid to rest memories and missed opportunities from school days. Only a handful of people remained even remotely civilised whilst the rest took great pleasure in redefining the World Health Organisation's definition of promiscuity. Everyone believed that they were again freshers but the roll of honour must be handed to the two individuals who persevered through bouts of vomiting, a bloody nose (through bumping into a speaker) and various other acrobatic demonstrations and then promptly refused to go home, ever. A night of sheer debauchery by one and all that would certainly make our ancestors turn in their graves, as people lost all sense of responsibility for a few hours. Friendships were cultivated and social diseases cultured, in what can only be described as one of the most friendly nights at Guy's bar. The only problem being the throbbing heads, and dehydrated bodies the next day.

'Friendships were cultivated and social diseases cultured, in what can only be described as one of the most friendly nights at Guy's bar.'

Laurence Boss (Fresher) on Cobham Carnage Night

'The most memorable part of the trip to Cobham was the coach journey, having all finally bundled onto the coach, the coach seemed to be travelling really slowly for about a mile and a half. We saw smoke billowing from the sides and fearing the worst another bus was called for but when the second driver arrived, all he did was release the hand brake! As the news filtered back the whole bus became filled with laughter setting the tone for the evening ahead.

As eagerly expected, we stopped off at a supermarket and the alcohol was purchased for the journey ahead. It had taken nearly two hours to reach Cobham, but finally we arrived. Not many freshers took part in this day as most were resting. At Cobham, a football match was started which left most people content or at least severely dehydrated. Most of my friends decided to leave when shouts of 'get the freshers' sounded from the upper-years. Overall a day for the upper-years who seemed to enjoy the day far more than us.'

Honor Oak Park - Freshers' trials

The heavens opened and the rain came down and what could have turned into a dreary day was saved only by the enthusiasm with which the Freshers attacked the trials. Some returned to familiar sports whilst the more adventurous turned a hand to something new.

A riotous night began early as the bar was besieged, and the various teams formed tables to allow the games to begin. Credit must go to the organisers, who tried to think of even the most minute details, and ensured that enough song books were provided to help initiate the freshers into what can only be described as another night of intemperance. Whilst these books may have added a degree of false confidence to their fate, it quickly became apparent that the pitchers of beer and bitter that kept arriving in a steady stream, were instrumental in producing that dizzy feeling for one and all!

'In keeping with tradition, the men's rugby team displayed all...The other teams, not wishing to be outdone, indulged even further, with excellent performances from both the women's hockey and rugby teams...'

In keeping with tradition, the men's rugby team displayed all.The other teams, not wishing to be outdone, indulged even further, with excellent performances from both the women's hockey and rugby teams, much to the approval of the inspecting crowds. The football team, realising that these distractions were interfering with their activities, retired only to find that the bar was now far too great a distance to travel for the state they were in.

By eight o'clock, the effects of excessive drinking had drained all but a little of their energy, and slowly the procession back home began. For some this became an adventure in itself and the helping hands of strangers and fellow students were warmly appreciated.

For those few stragglers who actually made it to the **Boombastic Night** (alias- 'Image and Attitude Night') the atmosphere was to put it mildly, tame. The evening was further complicated, as were all the Tommies nights, by the new positioning of the Gentleman's facilities in the basement. This is leading to an unacceptable situation, as negotiating three flights of stairs in an intoxicated state can only be described as a perilous journey and it is only a matter of time before an accident happens.

Friday- Fairground Attraction

With vivid memories of last years notorious Round The World, the powers to be this year were adamant to try and control the wild and riotous behaviour of the students, and prevent the extra strain that was placed on A & E staff last year. As last year's events involved the production of a code of conduct and the banning of alcohol sales at the bar, (for a period of 1-2 weeks) the expectations from freshers and non-freshers alike, were extremely high. This placed an excessive amount of pressure on the committee to provide an excellent end to the week, in what is generally regarded as the best night. A job they managed well, keeping all parties happy, involving a great deal of planning and even more alcohol and even more good luck.

'...the whole place was awash with people holding a multitude of different coloured drinks, some of rather dubious taste.'

The Spit was transformed in character to a Fairground scene, with a very large number of stalls including catch the wind-up duck (with a stick held in your mouth), mystic Meg's tarot stall, pinning various parts of Roger Mellie's anatomy onto him and an electric shooting gallery. No expense had been spared! Tickets were cheap and plentiful and the whole place was awash with people holding a multitude of different coloured drinks, some of rather dubious taste. (I'm sure at one point I was drinking anti-freeze and enjoying it!)

Paul Vig (Fresher) on Fairground attraction

'It all began at about seven o'clock when we decided to get down to Guy's bar and begin early. There we met the Bag Ladies who were fourth and fifth year students in drag as OAP's. They were carrying shopping bags and had tea cosies on their heads. They warmly greeted us with verbal abuse and then reached for their bags for open cans of baked beans which they hurled at us. We dashed for cover, and then retreated back to Wolfson House to lick our wounds.

We came back to the bar later on, to find the Bag Ladies gone, so we decided to get a couple of pints in. Then we headed upstairs to the Spit where the real festivities were beginning. The spit had turned into a fairground! We bought some tickets for the amusements and queued up to play, watching the other punters in awe as they played the weird and wacky games. The prizes were paid alcoholicaly either as cans of beer or strange cocktails that not only stained your teeth and lips in garish colours but also got you rather drunk. I played most of the games on offer but than had to partake in the 'drink a bottle of cider in one go' game (or rather try to) by some fifth years I had met beforehand!

At around ten o'clock we were all thrown out by security - apparently it had to end for reasons we never did find out about. I still had a few tickets left so I went up to the organisers and exchanged my tickets for a large glass of blue coloured gin (rocket fuel or antifreeze), treading carefully over a couple of Bag Ladies who had passed out on the floor!

It was quite packed in the bar and whilst I met lots of freshers, I realised that I would forget their names by the morning! After even more drinking, I discussed music tastes with the DJ by rifling through his records, and asking him to play some better tunes. This was in spite of over one hundred people dancing on the dance floor who loved or thought they loved the music. After even more chatting with other freshers I stumbled back to Wolfson House to collapse into bed and wake up with a very large hangover. An excellent end to my freshers week!'

Jamie Gailbraith - Social Secretary at Guy's

'From the off, we were thrown into a spin of frenetic nostalgia. Taken back to school, for an essay in pleasure. Cobham sports day was a good crack with a team bath to end. The tonic in the free flowing festivity was Soho golf, where Billy won with a long existing highly tactical pull. Tommies showed us in the exceptional words of Louis Armstrong that we can say to ourselves 'what a wonderful world'. Though alien to London and College life did not mean being lost in space at the quasar evening, which was one of the most popular nights, despite the two fire alarms The Fairground attraction fete was very charitable to the bag ladies. And lastly the Floating Ball added the spice to another very well attended and memorable first week of medical studies and will hopefully be an hor d'ouerve for the next five years.

No easy task for the organisers and an even harder physical task for the participants!'

The Committee

Tom Whitcher-President
Billy Challacombe-Vice president -Guy's
Kireon Rooney-Vice President-Tommies
Jamie Galbraith-the only one sober-Social secretary-Guy's
Simone Lester-Social secretary-Tommies
Nij- I know everyone, so no surname required-Bar secretary-Guy's
Andy McBride-bar secretary-Tommies
Anyone else who I have neglected or wants their name in print.

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BSc Graduation Ceremony

Thursday, October 4th 1995

Today was the day that all those BSc students were waiting for, or was it? The BSc, you have heard the nightmares, all those stories, gossip about students and tutors, the dreaded supervisor, the even more dreaded project and of course, those many nights spent in the lab - OOPS sorry!, down the bar. Today was the end of it all, would the students being repenting that they would never do it again, or was it all worth it. We were about to find out.

The day started by first of all, finding out about the aspirations that the students, families and the tutors held about the day. Chatting to the BSc tutors about it all, the impression was given that the BSc was an experience which would be invaluable to all the students taking part and just having done it would be the reward. Certainly 'doing' a BSc was an experience and at the end of the day, that was what was most achieved and it gave the BSc student a certain aura, only to which I think a BSc student can describe. Not to forget to mention the many practical things that were learnt, right now it is helping me write up this report, as I can type much quicker. We are now - 1) fearless of computers 2) can write up reports and projects 3) have an insight into research 4) thinking more before actually doing it and taking care not forgetting to mention 5) stress - what's that. So, if we were going to get all of that out of a BSc, what would the tutors get out of it. The reply - friendship, and the increased ability to understand the student and the whole concept of being a student. What was important though for the tutors was that today, they were going to meet the parents and other relatives of the students that they had been taking care of for the past year. This was a sense of satisfaction which was expressed by all the tutors spoken to, it was definitely what they were looking forward most to on the day.

'Which aspect of the day were the students most apprehensive about? - of course tripping on that stage!'

Before getting the views of the students, having a word with the makers and suppliers of the graduation gowns gave us a bit more of an insight into the graduation day. Ede & Ravenscroft were the suppliers to the day's event and their job was to prepare the students for the big day, trying to relax a few of them as some were quite nervous. The firm had been founded 306 years ago so it was guessed that they knew what they were doing. What do they do to make the student feel less nervous? well, tell a joke or two, calm them down as they put their gowns on, and of course carry a few spares around just in case.

Chatting to the students on the day, there was a sense of togetherness between the certain groups - it was like a high school reunion when you met someone who was your best mate when you were fourteen. The students had been waiting all day to put on their gowns, but were disappointed not to wear mortar boards, mainly for the sake of the photos that were going to be taken later on. Which aspect of the day were the students most apprehensive about? - of course tripping on that stage! Some were also concerned about whether their gown would fit them or not. When asked how they felt, most felt a little self-conscious but when asked what they would do to me if I was to inadvertently spill my drink over them, the reply was that I would have to 'lick it up' thereby providing me with the information that yes, there was a feeling of pride when you have that gown on. To all those readers who have gone through ceremonies like this one, it was an apt sentiment which I hope brings back memories. To those students who have not yet graduated, time will go by quickly. A chat to some past students who had gone through it all felt that the day was really mostly for the parents, but when asked about the BSc, there was a definite recommendation, a definite 'do it if you can', and as such, we are lucky at UMDS that the BSc is encouraged to such an extent.

'...when asked about the BSc, there was a definite recommendation, a definite 'do it if you can', and as such, we are lucky at UMDS that the BSc is encouraged to such an extent.'

Anyway, back to the event. The atmosphere in the grounds of Southwark Cathedral was lively, with all the parents and the students meeting each other. Many of the students were introduced to their friends' parents for the first time

and what was most said in reply to these meetings was that finally a face was put to the voice that many a parent had heard on the telephone on many an occasion. Parents also met other parents and they could all bathe in the glory of watching their own offspring achieve that first, becoming a graduate. It was definitely a day for the parents! There were many passers-by in the area and talking to a middle-aged couple from Canada, they expressed their delight especially when seeing a mother graduating whilst pushing her baby's pram around. The best part about the ceremony according to them was 'getting the family together'. Cameras were being clicked, camcorders viewing the whole event, and it was a beautiful day. Southwark Cathedral was at its best. Students were commenting about the BSc in general, it was a good thing and they had a really good time and also it was important because it was something that was quite different to medicine. The pressures in the job and especially nowadays with what is going on in the NHS, life outside medicine is becoming something very sacred indeed.

'It was definitely a day for the parents!'

So, everyone was ushered into the cathedral. As you walked in you could feel that this was going to be a big day. I still felt chills when I walked in that moment, similar to those that that I had experienced this time last year. It was going to be weird seeing it from the other side, you could not only feel proud and happy for the students that you knew, but for everyone involved, there were smiles everywhere. Sitting down you could see heads popping up as people strained to see where everyone was that they knew. Parents and co. were eager for this search, whether some of the students were embarrassed was only to be proved. It happened last year when there was a parent standing for at least twenty minutes continuously filming with his brand new camcorder, when a student sitting in front of me whispered to another student, 'What's wrong with that guy', to which I interjected, 'That's my dad'. Everyone was mumbling something or another, lots were studiously reading the programmes provided, obviously looking for that one name. An elderly lady in a wacky head -dress made the waves at the start. It definitely attracted attention, it was green, it was high and it was surprising it did not fall off her head.

So the trumpets blared, and the fanfare began. The procession was lead by Dr Segal and it contained all who we wanted to see and also lots of faces that looked important, were indeed important, but no-one had a clue who they were.

I guess part of the ceremony is to see the School in all its glory, prestige and tradition and to meet all the people who run UMDS, all the people who decide its future, all the people who we really don't see. The ceremony was started by the Very Reverend Colin Slee, the Provost of the Cathedral, who welcomed everyone, thanked everyone involved in organising the event, from his helpers in the Cathedral to the choir, from the calligraphers of the actual degrees to, of course, the students and their families. He welcomed us to an afternoon to which he hoped we would enjoy, but warned us to be practical. This was suggested in the obvious idea that we should applaud, but not for too long so it would drown the name of the next student being called. The second practical point - with new modern technology as it is nowadays, the mobile phone should be shut off, a comment that might do some good in the library.

'An elderly lady in a wacky head-dress made the waves at the start. It definitely attracted attention, it was green, it was high and it was surprising it did not fall off her head.'

Then Professor Cyril Chantler took the podium. People close to UMDS would be acutely attuned to what he was going to say. Professor Chantler started off by talking about UMDS from its formation in 1982 to the present day. He felt that the School was ever improving with many more applicants and many more students taking up the BSc - 53% this year and 20% of these students achieving first class degrees. The Dental School was now a forefront in research and more dental students were also taking on the BSc. Prof. cited the founder of Medicine - Hippocrates and discussed the characteristics to which made a good doctor - the caring, the compassionate and people who could contribute to society in general using their own qualities. To pass the A - level system was not enough, it was essential that we attracted these people for the future. For that, the Principal thanked the admissions team - Dr Robert Linton and others. The speech then progressed to the changing aspects of medicine but with the impetus on the old reasons standing firm. The doctor was not just a scientist, but a healer, priest and prophet. However, with the increasing demands, medicine was never safer yet education had to be in union with all this - hence the new curriculum. Sixty million pounds has been set

aside for the Guy's site and its development when the merger happens. As we know Guy's would become the centre of research and teaching and Professor Chantler was 'personally enthused' about working together with the increasing advantages for a multifactorial set-up. Opportunities would arise that would make this a project to look forward to and that this had not been possible without the immense support of the Board of Governors and the Trustees. From one hot topic to another, the NHS. He started with the emphasis on how important it was, it was better healthcare and the best delivered, but had been under constant criticism. However, the future was safe in the hands of the students and this was the note that Professor ended on. No surprises though.

'...many more students were taking up the BSc - 53% this year and 20% of these students achieving first class degrees.'

The actual graduation ceremony then started and you could hear the many footsteps as the students made their way to the stage. Mr Andy Baker, the Registrar, had the job of announcing the names of the graduates, whilst the degrees were being presented by the Vice-Chancellor, Professor Andrew Rutherford, CBE. The job of announcing the names was a task well completed by Andy Baker and after one particular name, Mr Baker raised his eyebrows, probably with the sense of relief of pronouncing that name correctly. Not only was this ceremony for the BSc graduates of which numbered a hundred on the day but many other graduates, including MSc (forty-four), PhD (twenty-seven), MD (ten) and two DSc degrees. A total of fifteen students had excelled in pre-clinical and clinical subjects and were awarded special prizes. Watching the graduates walk up and collect their degrees was a sight to behold. The graduate would wait patiently for their name to be called out, move on a command which came from 'somewhere', walk confidently to collect what they were here for - their degree. This was the moment that most

'Not only was this ceremony for the BSc graduates...but many other graduates, including MSc (forty-four), PhD (twenty-seven), MD (ten) and two DSc degrees.'

of the students were waiting for, it gave that whole year of hard work, an ending to which they will always remember, and one moment in which they would look back on with their own personal thought. Were they worried about tripping over or something, at that moment the world closes to shut out everything in order to concentrate this special feeling. Still today though, if someone tells me that I am a graduate, I look upon them with a sort of deja-vu feeling, yet not believing them at the same time.

What must be said though is that the actual degree presentation is over so quickly and yet still gives that amazing satisfaction. A couple sitting next to me were eagerly awaiting their daughter to come up on the stage. As Andy Baker said the last syllable of her surname, the dad was up on his feet, with a loud, quick and full of effort clap just to show his immense appreciation for that moment in his life. You would have waited all that time for just those few seconds, but it's worth it. What else can be said at this moment, well I was not sitting next to the students but you could see them going back to their chair, sitting down and carefully reading that piece of paper - of course the real one had been sent in the post a few weeks previously but this was just as good. The actual degree presentation here had lasted half an hour, and what would progress over the next hour or so would be very important to the rest of the day's activity, yet to the graduate who had achieved what they had worked hard for, patience may become a virtue that would be tested.

'The question is, what does UMDS stand for - that is still a debate that is yet to be resolved'.

The actual presentation had finished, and now, Professor Andrew Rutherford greeted everyone and congratulated all those involved. His speech did not really centre on anything specific or pick out any issue. The talk was funny, to the point and most importantly achieved smiles and a few bouts of laughter from the captured audience. He did talk about the merger, said that our name would not be lost as there was too much to lose in that way, it would be preserved as it was 'embedded in the history of Medicine and London'. From the merger though, there would be managerial benefits, academic benefits and not just medicine and dentistry was important but so was the wide range of science. A few recaps of certain meetings he had attended in his life were touched upon, with morals and messages coming from these stories. He was

reciting a speech given from a Professor at Yale University who had decided to put forward the university's aspirations, all beginning with the initials of the name, ie the letters Y, A, L and E. This respectively stood for, youth, ambition, learning and education. The question is, what does UMDS stand for - that is still a debate that is yet to be resolved, who knows what would be our initials then.

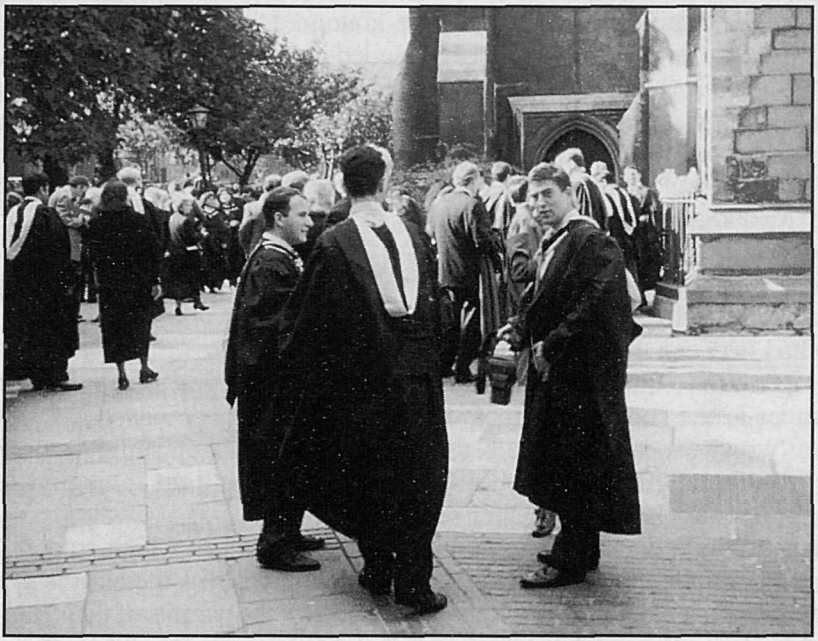
Our Music Society then gave us three songs to which they sung beautifully, and in the atmosphere of Southwark Cathedral, with all its splendour from inside gave you another special moment. It was a time to reflect then, for the BSc graduates their whole year, and in a certain ceremony in a few years time, more will be thought about once there is an MBBS and a BDS in the air. The music repertoire was then followed by the presentation of the honorary degrees. Six distinguished people were honoured, all had a connection with UMDS, not all were scientific. This included indeed our own Chancellor, The Rt Hon The Lord Butterfield Kt, OBE, who was not presenting the graduates with their degrees, as it was agreed earlier on because he himself would be receiving one. What was special about this moment was how their life stories were recollected and it seemed that these people had done so much for science. For a layman, we were surprised to actually meet these people who had between them given us cataract operations, introduced the fluoridation scheme and discovered major advances in the control of circulation by the sympathetic nervous system. It was a 'wow' experience. The National Anthem was then sung, final thanks given by the Clinical Dean, Professor Ian Philips and an invitation to the reception to take place in Glazier's Hall.

'The BSc, was it worth it? At the end of the day, I think it was.'

The reception was a celebration of the day's event in which students and parents were allowed to get together again and there was the chance to meet all the tutors. The tutors were happy to track down the parents of their students, ready to do it all again but believed that the BSc was not right for everyone and should only be done if you have a clear idea about why you wanted to do the BSc. Chatting to the students, it seemed that they all enjoyed it but could not really remember the actual 'bit' when they received their degree. It was all over in a flash, there were no worries about falling over, no worries about other

things, all they had to look forward to was what they were going to do tonight, some were being taken out by parents, some were out for a night on the town. The BSc, was it worth it? At the end of the day, I think it was.

Raj Sinha



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An Interview with: Dr Mary Dyson

Dr Mary Dyson is currently head of the Tissue Repair Research Unit at Guy's Hospital. She is also extensively involved in the teaching of pre-clinical and BSc students, and still finds time to be an editor of Gray's Anatomy. Earlier this year, she suffered a near-fatal CVA stroke but managed to recover swiftly and is now as busy as ever. I caught up with her during a gap in her hectic schedule and managed to ask a few questions giving an insight into her life and achievements.

Could you tell us about your student days and how it all started?

I studied at Bedford college in Regent's Park which is part of the University of London, where I gained a first class degree in Zoology specialising in developmental biology. I had always wanted to do biology and medicine never really appealed to me.When I first came down from Yorkshire at the tender age of seventeen I was released from a convent school into London so you can imagine I had a great time. My first term was one long party but then the exams came. As I came 5th I was very pleased, but the head of department called me to see him and innocently I thought that it would be congratulate me. He didnt; he said 'you have a scholarship to the University of London, you shouldn't come 5th, you should aim to come 1st'. I was furious because I thought I had come to London for a good time, but I then realized that both were possible and reorganized my time and never settled for 2nd best again. I remember once when exams were approaching we needed to practice our dissection on birds, so some lads from another college soaked corn in whiskey and fed it to the pigeons in Trafalgar square. They came back with at least ten birds which definitely helped us pass our exams!

What was your next career move?

I was invited to do a PhD at Bedford on the Busk Howell research scholarship and on completion of this I applied for a job at Guy's Hospital to work with Professor Jack Joseph on a wound healing project in the anatomy

department. This was in 1964 and I've been here ever since. I moved through lecturer and senior lecturer posts and subsequently became a reader in the biology of tissue repair. In 1985 I started the Tissue Repair Research Unit which has grown from a department of 3 to 25 people including the students.

When and why did you get involved in teaching students?

I first started giving tutorials during my PhD at Bedford college and when I came to Guy's I continued by demonstrating in histology. After this I became involved in teaching gross anatomy. I now spend some of my time teaching the dental students histology, but mostly I am involved in the teaching of BSc and PhD students. I really enjoy teaching as I get instant feedback and know quite quickly if students are enjoying themselves and learning. If they're not then you should change your style, I know I try to.

You have the reputation of being one of the nicest people to have in a *viva*. Have you ever been nasty to anyone?!

Really? I don't see the point in being nasty, vivas are ways of finding out what people know, not necessarily what they don't know. If someone makes a mistake and it's appropriate, I correct them and give them another chance. I hope people learn from *vivas*, I don't feel that vivas should be occasions to be feared they should be looked forward to and learnt from. The other thing I try to remember is that this lady or gentleman may be my doctor in a few years time and had better know the anatomy of whatever. I try to be fair, I may err on the side of kindliness but I don't consider that to be an error. I want students to have enough confidence in me to tell me what they know, not to be so terrified that they are incapable of articulating their knowledge.

How much do BSc students contribute to the Tissue Repair Research Unit?

Every year for the last three years we have run a course as part of the BSc selection offered by the division of Anatomy and Cell Biology. I would like to see it developed into an independent BSc in tissue repair. It is a specialist course which is growing in popularity and as it is clinically useful it will help you as doctors later. I hope that when the students become doctors, they will put the patients first and not just treat their wounds but take a more holistic approach to the patient's management.

Recently, six of the BSc students have had papers or posters accepted for presentation at the 5th annual meeting of the European Tissue Repair Society in Padova, Italy and two more students have had papers accepted for oral presentation at a physiotherapy conference in the Hague. Students do original research and if it's good enough, then they have the opportunity to submit and present it. So, yes the BSc and PhD students are very important, in fact everybody is equally important in this unit.

How did you get involved with Gray's Anatomy?

I am one of the editors of the 38th edition and I was an editor of the 37th edition. I have a love-hate relationship with Gray's Anatomy. It is a wonderful book and I am proud to be involved with it but it kills people; two of the editors of the 37th edition have died in the last few years - Professor Roger Warwick and Professor Peter Williams. It was a great pleasure and priviledge to work with them both and I learnt so much. It was they who turned me from a zoologist into an anatomist. Professor Roger Warwick asked me, after reading some of my papers, whether I would like to join them as an assistant editor on the 36th edition. He told me to start on the last page and work backwards, which is what I did.

I was also very fortunate to work with Dr Laurie Bannister, whose artwork is superb. I can visualise things but I can't draw them, so my drawings tended to be thumbnail sketches whereas Laurie's, were so good you'd wonder why he needed an artist.

What other academic interests do you have?

I was very lucky in 1988 to get a Pioneer Award for work I had done in ultrasound. It was presented by the American Institute of Ultrasound in Medicine and the World Federation for Ultrasound in Biology, in recognition of contributions to the development of medical ultrasound. I was very proud to receive the award and it was lovely to go to Washington. All the work I do is team work and it was the team that really got the award. I was elected an Honorary Fellow of the American Institute of Ultrasound in Medicine the following year for what they called outstanding contributions in the field of medical ultrasound. Then in 1990, I was made into a physiotherapist which I thought was wonderful and elected as an Honorary Fellow of the Chartered Society of Physiotherapy for research into the biological effects of electrother-

apy. Two years ago in Japan I was elected in my absence President of the International Laser Therapy Association. In this role one of my jobs was to run a meeting in London which we did as a team and we have now brought into being a World Association of Laser Therapy, the acronym of which is WALT. My husband is called Walter and he says that they should add European Region just to round it off. The first congress is in Jerusalem next May and I have been invited to give a plenary lecture there.

You are currently developing a new ultrasound scanner, could you tell us about it?

The unit has been responsible for developing a new high resolution ultrasound scanner in conjunction with a very good electronic engineer, which allows us to montior wound healing non-invasively. A company has been formed by UMDS called Quality Medical Imaging Limited,of which Dr Steve Young and I are joint managing directors the majority shareholding is held by UMDS. We are hoping to take the machine, which I think is the best one around, from a prototype to a marketable product. We have links with companies in America that are interested in working with us. There is no point in having a bright research idea that blossoms in the laboratory and then dies. I want to see this machine out there being used to help people as it could literally help to save limbs by showing surgeons how far an injury goes and how far they need to debride. It can demonstrate how well a wound is healing or if it is getting worse, which is far better than simply eyeballing it by looking at the surface.

This machine is an non-invasive 'biopsy', it helps to make the invisible visible and due to very good image analysis we now have images that can be made very doctor friendly. We are indebted to colleagues at UMDS, in particular Dr John Lynch. We can use image analysis to convert an area of interest into fractal signatures, curves that can be used to demonstrate quantitatively changes in the underlying tissues. We can show the beginnings of a pressure sore before it can be seen on the surface, the development and removal of oedema and healing rates. The development of non-invasive techniques are going to help surgeons make the most informed decision, as an adjunct to their own clinical judgement. The project for 1996 is to build up a database on wounds, their development and healing so that future patients' injuries can be compared to it.

Could you tell us about your accident?

It occured at approximately 1.45pm on the 4th of April 1995. I remember that I was due to give a lecture at 2pm, so I got my slides ready and went to the ladies. I must have looked pale because one of the girls in the lab asked if I was OK. I did feel a bit sick but just put it down to butterflies, which I still get before every lecture. As I did not return within five minutes, someone came after me and saw my feet at a strange angle below the door. My deputy, Dr. Steve Young was called and bashed down the door. Afterwards he said he'd always wondered what it was like in the ladies! They gave me oxygen within minutes which I think made all the difference. The people at Nuffield house, the private wing at Guy's, organized a wheelchair and oxygen, I was assessed rapidly and transferred to the Maudsley Hospital. Four days later when I had stabilised I was operated on. They waited until angiography could find out exactly where the problem was - I had a ruptured Berry aneurysm on a major branch of the right cerebral artery.

When I came round I couldn't believe what had happened because I could do everything. I think I remember everything, but what stands out clearly was that every half hour they asked me my name, the date and who the prime minister was. I got so fed up that evenrually I said 'Major thinks he is!' after which they left me alone. I then went back to Guy's to recuperate for several weeks during which I still chaired meetings from my hospital bed after which I went home to finish recuperating. The only residual effect that I have now is a slight balance problem, so I try to avoid rush hour. The idea was originally to come in late and go home early, but in reality I come in late and go home late, there is too much to do, but my work is fun and I really enjoy it.

My husband Walter has been very supportive. Another thing that helped me get better was that so many people came to see me; students, members of my team and other staff. I remember 2 students inparticular, they brought me a potted plant which was kind and said 'When are you going to be ready to teach us again?'. This cheered me up and I thought to myself 'I am going to get better and be teaching you before you know it'. I told them which vessel had been affected and instructed them to go away and find out what it supplies. I'm still waiting for the answer!

What are your non academic hobbies and interests?

I enjoy travelling, so whenever I am invited to exotic places I jump at the chance. Fortunately, my husband does too so we are able to travel together. I also enjoy coarse gardening, in other words I'm not very good at it but I like throwing plants into little holes in the garden and hoping they come up. When I get the time I go to the theatre and listen to music.

If you could have your career over again, would you change anything?

My only regret is not starting the Tissue Repair Research Unit at least 10 years earlier, if that had been possible, as it is such an important subject. When I came to Guy's I knew I wanted to do research work that would help people, I knew I wanted to find things out and this gradually crystallised into wanting to work on aspects of wound healing and tissue repair. It's a fascinating subject, academically stimulating and very exciting but it is the relevance of this work to clinical practice that matters.

What are your plans for the future?

To head the best Tissue Repair Research Unit in the World and to gather around me people of excellence. I have been extremely lucky both in the people that have joined the unit and the fact that we have managed to bring in funds, as without money you cannot undertake research. I hope to be a good research worker and a good leader, encouraging people to do their best.

Naomi Streeten

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BT Global Challenge

'The Challenge of a Lifetime'

Since my training at Guy's Hospital in 1957, I have continued in nursing, except for a brief period having two children, and recently changed slight direction to work in the theatre department at the Exeter Nuffield Hospital, Devon. Now, at the age of 56 I am taking on the biggest challenge of my lifetime, to take part in a yacht race around the world.

I have secured a berth in the BT Global Challenge, 'The World's Toughest Yacht Race'. This race is organised by Chay Blyth who first took the route around the world against the prevailing winds and currents in 1971. On September 29th 1996 I will be part of a team on one of the fifteen identical 67 foot steel yachts setting sail from Southampton on the first of six legs in the 30,000 mile race. This yacht race, previously the British Steel Challenge, generates more media interest than any other. I will be competing in every stage of the 10 month challenge. Leg one is a month long 5,000 mile race between Southampton and Rio de Janeiro, through the Bay of Biscay and the Doldrums. Mid November will see the start of the 40 day second leg from Rio, the 7,000 miles around Cape Horn where yachts will encounter the Roaring Forties, in to Wellington. The next 1,250 miles to Sydney will start at the beginning of February 1997, taking approximately one week to cover. We will then race across the Southern Ocean to Capetown arriving early March taking approximately 40 days to cover the 6,300 miles. Leg 5 is the 7,000 miles between Cape Town and Boston, taking just over a month, and the final 3,000 mile leg back to Great Britain will see the yachts at sea for just over a fortnight arriving back in Southampton in mid-July 1997.

I have just completed a two week structure intense training sail with 12 other crew volunteers, off the South West Coast covering almost 1,000 miles. This training covered every aspect of sailing, including hoisting and lowering sails, spinnakers and sail changes. We also learnt the intricacies of how the engine and water maker works as well as the complexities of the plumbing systems - first hand knowledge learnt by one female volunteer when the heads

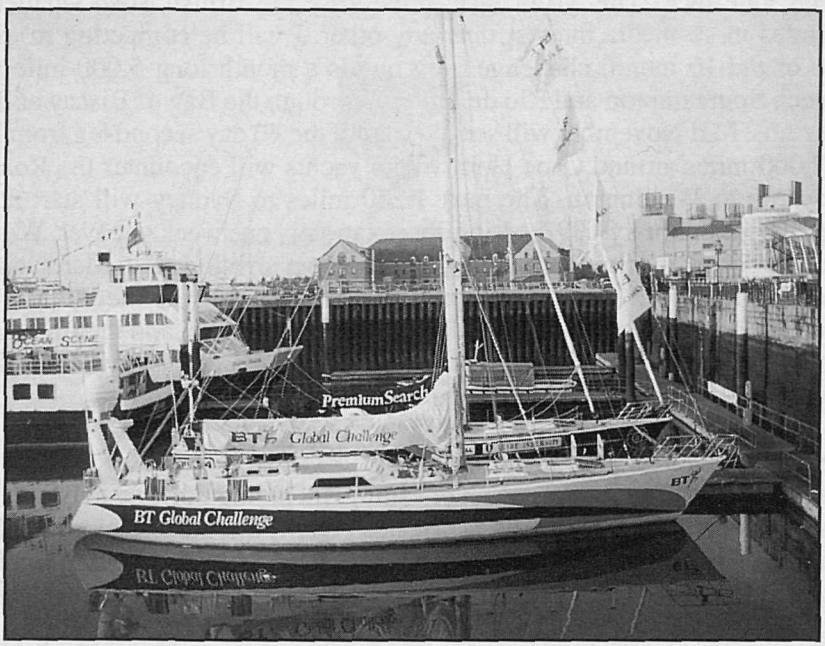
or toilet was blocked! Every volunteer experienced a trip to the top of the 85 foot mast, one experience I don't want to repeat.

Each yacht will have a medical representative either a doctor, dentist or nurse and as well as being that representative I may well be responsible for the planning and organising of the provisions for the crew for the whole race, a mammoth task. Following our training the volunteers will be selected into 15 balanced crews for the corporate sponsors to pick their crew at random. All 15 yachts will compete in a mini race of a 1000 miles next July around Ushant.

Participating in such a challenge is a privilege but I also have to raise £18,750 in order to take part. I have raised half of my target figure from a variety of sources but would welcome any further sponsorship however small.

I still have a lot of hard work ahead of me with training and maintaining a fitness programme, but I am determined to succeed in this 'My Challenge of a Lifetime'.

Andrea Carter
Guy's Hospital 1957-61



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Acute Medicine

The book to have for any junior doctor wishing to have at his or her fingertips a logical approach to assessment and management of most of the acute medicine, including medical emergencies they are likely to face in the hospital.Its concise format and easy to read style means that information is readily accessed at a glance, while the numerous algorithims help the inexperienced to develop a structured approach to clinical problem based solving. Add to this, invaluable time-saving dose conversion charts and tables, if there is a book that all houseman should possess, this is it. (**Acute Medicine, Sprigings, Chambers & Jeffrey, Blackwell Scientific, ISBN 0632036524, £16.95**).

J Kumaradevan

Clinical methods

An excellent updated version of this very useful aid to history taking and clinical examination is now available. The latest edition has a more 'user-friendly' layout fully complemented with colour, boasts a greater number of short list tables and the information is readily accessible and easy to comprehend. This is surely the aim for every textbook but not all are able to succeed. In this respect, Clinical Methods stands out. It is an excellent buy at £16.95 and is well worthy of purchasing again even if one already owns the previous edition.(Hutchinsons Clinical Methods, Swash, Saunders ISBN 0702016756, £14.95).

D Sen

NURSES - BEWARE ALTERNATIVES!

Complimentary, or alternative medicine, as it used to be known, has been given a great boost in recent years by both nursing journals and exhibitions, and by nurses themselves. The recent Nursing Times event 'Professional Nursing '95' held in London, even had a Complementary Therapy Villa! Of course, such commercial organisations as these publishers can hardly be expected to stand aside when the bandwagon starts to Roll, but I wonder how many nurses are aware of the association HealthWatch which seeks to set the same standards for these remedies as are set for the 'mainstream' remedies?

And, according to one authority, they do not come out of these studies in a very good light. Thurstan Brewin argues that many diagnostic techniques such as irridology and reflexology are little better then astrology or palmistry. He is an oncologist, but did not comment, as perhaps he might, that amongst nurses maybe many believe in the latter!

He did, interestingly, though point out that one double-blind trial, of women taking evening primrose oil for pre-menstrual tension, found that this potion was no more effective than ordinary liquid paraffin.

We all want to be better nurses, and participate in providing better care for our patients. But remember 'curing' is a term also used in the process of producing bacon! All treatment requires participation and co-operation by the patient, but much of what passes for effective treatment through complementary therapies can apparently be counted for by little more than co-incidence. Magic can play a powerful part in our lives, and if accompanied by the right 'chat-line', may incline us to believe much has been achieved in the name of a complimentary, or alternative, therapy, when in fact the wool has been pulled over our eyes.

Mainstream medicine, and along with it nursing opinion, has been cautious about adopting anything but a polite approach to these complementary therapies in recent years. A BMA report in 1993, - 'Complementary Medicine - a new approach to Good Practice' - was careful to avoid criticism of this 'fringe medicine'.

A lot of the popularity of fringe medicine points to its deep roots in the past and in the East. This follows disillusionment with our own world, and despite the tremendous strides made by mainstream medicine, which does not make life perfect and death non-occurring, complementary therapies, which needles to say have equally not achieved these aims, are sought out under the guise of offering a 'holistic' stance.

Now, no one need be critical of the holistic approach - but this does not mean ignoring the rigorous trials main-

tain by doctors and nurses using 'orthodox' or 'mainstream' methods.

One of the oldest and best known of the complementary therapies is acupunture. Felix Mann, who practised in this field concluded in his 1977 work, 'Scientific Aspects of Acupuncture' : 'After some years I felt I had to some extent mastered the subject: I knew what the ancients said, and also what was preached in this century in the East and the West. It was only then that I seriously examined the validity of all that I had learnt, only to discover most of it was fantasy. Acupuncture points do not exist, meridians do not exist, and most of the laws of acupuncture are laws about non-existent entities'.

Practitioners of complementary therapy often have less regulation and accountability than nurses and doctors who work in the mainstream field.

Nurses who attempt complementary therapies to their own practice should be wary: the UKCC has rules governing the accountability of each practitioner, and if patients are led to expect results from complementary therapy that do not transpire, where does this leave the professional nurse? If these therapies are offered as some form of comfort for diseases with no known 'cures', then maybe their role is clearly defined. But often, promises made on behalf of these alternatives may not be realised, as they find their place in the market, it is the rules of the market which apply, and not those of ethics and good health which mainstream practitioners usually employ.

We must not forget that many medical conditions are self-limiting, or may resolve spontaneously, and therefore successful 'remedies', may be based on a false assumption. Much of complementary medicine's success, like miracles, is anecdotal; until the complementary range is ready to undergo the same rigorous trials as that of the mainstream, it will be wise for nurses, both for their own professional standing and the benefit of their patients, to beware of claims that they cannot read about the tests for, or test themselves.

Denis Cobell

Letters

We would like to hear your views on any issues raised in any of the Gazettes, or anything to do with Guy's. You may have an opinion you would like to share with the rest of the readership. We would like to see some of your points published in future issues. If you feel you want to air your thoughts, please write to the editor.

You are reminded that it is the editor's discretion whether to publish a letter and that derogatory personal references to any individual will not be acceptable. We will, however, do our best to let you have a say.

Deaths

FRANKLIN, John Bungoyne, aged 81 years, beloved husband of Betty, and a loving father and Grandfather, died on August 26th after a long illness endured with great courage, and humour.

HENDERSON, Ian Dalton ('Granny') FRCS, qualified 1943 from Guy's. Died suddenly at home on November 7th, 1995

WATSON, John Stewart Ferra, died 17th September 1995, aged 83, after a stroke. Educated at Marlborough College, St John's College Cambridge and Guy's Hospital. Qualified 1938. Served in the RAMC throughout World War II and for many years afterwards, then as a Families' Medical Officer in Aldershot. He is survived by his wife, Rosemary, three children, one of whom (Neil) qualified at Guy's in 1967, and eight grandchildren.

Rugby

Saturday, 15 September 1995 Guy's 1st XV v Old Guildfordians Courage League Match Away Lost 13-57

This year the Courage Leagues began earlier than ever before on the third Saturday in September. Guy's had already played two warm up fixtures against Esher and London Irish and had been training hard for several weeks. This first match was against a side who beat them last year and who narrowly missed promotion from the League and were runners up. It was with some trepidation that we faced again this early since not only do Hospital sides take a little longer to organise than Club sides, but also the day was wet and windy. Nevertheless Guy's were going to play to a game plan of moving the ball wide and letting the wings have as much as possible. Guy's applied the pressure early on bringing the backs into play and both Cola and Gush had early forays into the opposition 25. However an early penalty in the kickable position was not converted by Guy's. The early exchanges were fairly even with both sides feeling their way in the first competitive match. At this stage the forwards were securing the ball and after two or three attempts by the back row to get over near the posts we were awarded a penalty. However rather than kick the ball, it was passed out quickly for Breeze to go over then converted by Gush. The opposition forwards then began to get more into the game. At times Guy's pack was having difficulty containing Derek White the ex-Scotland back row player who appeared in odd positions throughout the game including on the wing, possibly reflecting his fitness as much as his versatility. This pressure was rewarded with a penalty to Old Guildfordians and then, while Capt. Billy Challacombe was off the field with a head injury, an unconverted try. A matching penalty by Gush left the score at 10-15. Our worst fears were realised in the second half. A series of mistakes on the Guy's side including a knock on and a mistackle allowed Old Guildfordians in for two converted tries, stretching their lead to 35-10. Guy's then submerged into a fairly lethargic period and although nearly all players showed individual commitment, the lack of team training and in certain positions fitness began to show. The opposition scrum half had been a thorn in the flesh throughout the match and was allowed to sell two outrageous dummies in the centre of the field and run over for two tries. Guy's showed that they still had fighting spirit by then gaining access to the opposition half and a series of raids on the opposition line nearly lead to tries but the combination of a slippery ball, bad luck and mistakes allowed in the end the opposition to break away and score yet another try before the final whistle. Overall this was a rather disappointing performance after a good

start. Final score certainly flattered Old Guildfordians and the Guy's side will be disappointed to have not got their campaign off to a better start. There were enough good performances however, particularly by Barrio in the 2nd row and Ryan and Challacombe in the back row to suggest that better things are to come. The scrum was solid throughout and Guy's really had sufficient ball to make much better use of it. The kicking however was woeful and it was a surprise on a wet day not to have at least tested the opposition backs once with a high up and under, and perhaps trying to run the ball from all positions under acute pressure in wet conditions was a little naive. Team: L Hostert, D Evans, D Baladasan, E Barrio, M, Ansell, B Challacombe, G Ryan, P Davis, J Davies, U Ekeowa, R Breeze, M Jenkins, P Gush, G Lawton.

S.J.C.

1st XV v Gosport 23 September 1995 - League Match at H.O.P. Won 13 - 5

In contrast to the previous week's game. Guy's turned up to play their second league match and the first at home on a beautiful day at HOP. After the overnight rain the pitch was soft but with a gentle breeze, ideal rugby playing conditions prevailed. The Club was desperate for a win after two losses. The match kicked off late when Gosport were caught in traffic, but the early exchanges were fairly even with a missed penalty by both sides. However, Guy's were looking much more eager than the previous week and were able to apply pressure to the Gosport team and particularly pressure around the base of the scrum. An early dropped goal by Davies was not allowed under the rule which does not allow a dropped goal from a free kick until there has been a breakdown in play but, undeterred, further Guy's pressure was rewarded with a penalty by Davies. The remainder of the first half was all Guy's. A series of attacks mainly through the middle kept constant pressure on the Gosport line. Unfortunately, the combination of good defence by Gosport, along with a number of errors, kept their line intact. Guy's perhaps should have spread the ball wider and, on two occasions, there appeared to be a two man overlap before the ball was taken inside rather than outside. Guy's were a little unlucky and certainly frustrated at not scoring. At half time then it was only 3-0 to Guy's but a dramatic improvement in performance after the previous week. Immediately after the restart Guy's got the try they deserved when Jenkins went over the near posts and Davies converted. At this stage the forwards were looking very steady in the scrum though winning relatively little ball in the line out. The return of Murphy at scrum half enabled him to show all his cunning and put the opposition scrum half under pressure. He was more than ably supported by the Guy's

back row, particularly Greg Ryan who together with Llewellyn and Davies won a considerable amount of ball in the loose. Neil Davies yet again showed what a valuable player he is to Guy's with thoughtful long kicks relieving pressure at appropriate moments and up-and unders putting the opposition under pressure. Guy's midfield looked very solid and Mark Jenkins had an outstanding game both in attack and defence. Very little passed the two centres throughout and Ekowa on one wing and Shaeffer on the other had several opportunities to show their paces. A further penalty by Davies stretched the lead to 13-0 but Gosport had missed several penalties which they were regularly awarded during their intermittent forays into the Guy's half. On one of these occasions, the Gosport winger broke away and scored in the corner for an unconverted try to leave the score 13 points - 5 which remained the final score. This was a very good team performance, the tackling throughout the side was impressive, particularly in mid field and round the base of the scrum where it was difficult to recall one successful move by the opposition and where all their attacks were snuffed out. This was not without costs, since at various times during the match Challacombe, Davis and Barrio all needed medical attention. This might also have applied to Jenkins if one of the haymakers thrown by his opposition centre had connected. Fortunately none of them did, and if was more a sign of the frustration felt by the opposition backs in the face of some fierce tackling. The Guy's side thoroughly deserved their win. Rose at Full was calm and sensible and Murphy at scrum half had a very good game and tried a sufficiently large number of unorthodox moves to keep the opposition back row attentive. Team: L Hostert, Finnbar, D Baladasaran, B Challacombe (capt.) E Barrio, W Llewellyn, P Davis, G Ryan, J Murphy, N Davies, W Shaeffer, M Jenkins, Scott, U Ekowa, M Rose.

SJC

Guy's 1st XV v Warlingham. 30th September. Away - Courage League Game

Fixture lists these days are dictated from Twickenham and Guy's found themselves playing their third league game on consecutive Saturdays. Mercifully it was a dry day which Guy's always find easier than playing in the wet and on a nice day at Warlingham on a grassy pitch the match kicked off on time. After initial early pressure was repulsed, a quick break up the field was rewarded by a penalty when the opposition was caught of-side and Guy's found themselves 3-0 up before a single scrum had been played. Very nice passing movements set the winger free who tore down the pitch but did not quite make it. The resultant scrum was won by Guy's and Rose went over for

an unconverted try. This immediately lifted Guy's morale and, for a spell, put the Warlingham line under extreme pressure. However, at the point of scoring, a wayward pass by Guy's was gratefully accepted by the Warlingham wing who ran the length of the pitch to score under the posts. Guy's put this behind them and at this stage in the game were winning a fair percentage of the ball. Barrio was doing extremely well in the line-out with the loose ball being ably cleared up by Davis and Challacombe. They were also looking comfortable in the scrums and looked under no pressure on their own ball. However, the game was very even and the penalty to Warlingham took them into the lead 10 points to 8. A major incident then occurred which ended the game as a contest. The Guy's centre, Scott, pulled a hamstring and had to go off. The substitute had been runnng the line but the referee refused to allow him on to the field in lieu of one of the Courage League's instructions which states that the touch judge should not be a substitute. Eventhough the touch judge was immediately replaced, the referee took the view that the substitute was effectively disqualified from the match and so Guy's played the rest of the match with only 14 men. Even when a further injury (to Barrio) occurred and he had to go off, the referee still refused to allow the Guy's substitute on to the field and thus Guy's played the last 10 minutes of the match with only 13 men. Not only did this incense the Guy's side and supporters, but also the Warlingham side. Warlingham made it quite clear that they were happy to accept the replacement, but the game was effectively spoilt for all participants and spectators from that moment. With the benefit of a continuous overlap and some bizarre decisions by a referee who was now clearly rattled by the hostility of the crowd, Warlingham then ran in several tries for a 47 to 20 points victory. No doubt the Guy's club will learn a lesson of a referee who thought that his interpretation of the letter of the law was more important than the spirit of the game and was prepared to sacrifice a game to this end. In spite of being down to 13 men, Guy's finished with a fine flourish and, to the appreciation of the crowd, scored two late tries through Breeze and Rose.

Team: D Baladasaran, A Mislen, L Hostert, E Barrio, A N Other, B Challacombe, G Ryan, P Davis, J Murphy, N Davies, R Breeze, M Jenkins, S Scott, G Bevan, M Rose.

SJC

Guy's Wanderers XV v London Irish Seventh XV. 3rd September Score: 33-5

Although this fixture may sound like a rather socail affair, the Guy's XV were effectively a 3rds team and the London Irish were probably more 4ths than 7ths and so a hard fought match ensued. Guy's were captainless for the first half with Miles Walkden turning up late and deciding to rest himself to allow Pete Morgan to play scrum half. However, the Guy's backs always looked dangerous and, if given time and space, were bound to score at some point. So the interesting battle was up front in the forwards led by Big Rich and Pit Pony who was all over the park like the 'plague'. With Guy's taking even honours in lineouts and scrums, a quick ball out gave Guy's the first score with Dave Quick going over in the corner. At half-time, Guy's were 3 tries ahead to nothing (Duncan Perry and Ravi Singh scoring the others), though they needed to secure and retain possession in the forwards and get the ball out faster to the backs if they were to advance on this.

For the first part of the second half, Guy's then became under pressure; trapped in their own half with a series of lineouts and scrums. However, their relentless tackling in defence kept the Irish out and eventually cleared the lines. Straight away, Guy's then scored through Shay Reading to knock the stuffing out of the opposition. However, the Irish countered with a try in the corner, engineered by the devilish Pete Morgan who had swapped from our side with Miles to the Irish centre. He paid for this later in the bar! but it was Guy's who finished off the job with a try by Pit Pony and nearly from Scotty Simpson who had overnight developed skills on the flank. Unfortunately the Irish right wing had to go off in the second half after a 'collision' with Duncan Perry and it was his brother Ross who converted four of the tries (was he wearing predators?) to ensure the result was never in doubt in this hard fought but fair contest.

Team: I Soulsby, E Lams, R Clinton, E Lawson, S Allen (Bean), S Simpson, P Pony, C Smith/G Mullins, P Morgan/M Walkden, R Perry, D Perry, R Singh, S Reading, D Quick, M Lewis.

S Allen

Football

2nd XI vs LSE V
Saturday 14th October

The second XI made a triumphant start to the season with a 3-2 win, at home, against newly promoted LSE V. However, the youthful home side were unlucky not to get many more goals against a side which were not comfortable in this divivison.

UMDS II were given an early breakthrough by a goal from the head of the shortest player in the team, Nifio and from the onwrads the pace was set and determined by UMDS. The 'Blue and Gold Army', as we are now popularly referred were by far the stronger side in the middle of the park (excellent work by Kuram), and it was here that the game was won. However, the schoolboy footballers failed to convert possession into goals and at half time the score remained as 1-0. A lapse in concentration from an LSE corner in the second half allowed the visitors to equalise and brought more excitement in to the game. The UMDS response was immediate and very clinical, with neat football which was rewarded by an excellent strikers' goal from Ross 'Golden feet' fresher. The midfield strikeforce would have added a few more if it was not for their deep desire to play one-on-one football (alas the youthfullness). Then followed what was surely a 'ginning offence' when the UMDS stand in centre back, Ugo, gave the opposition a free shot at goal and the score was again levelled. What looked like victory slipping away from us was soon rectified in the last five minutes by none other than 'Golden feet' himself from a well taken free-kick from the veteran full-back and former Cobham Tiger, Guha.

Thus, a successful and eventful afternoon off football was culminated in a touch of experience, showing that old is gold, even in the new 'Blue and Gold Army'.

Team: Argi, Lai, Ugo, Redbond, Riki(c), Imi, Dave, Neil, Nif, Kuram, Chidi, Ross, Noel.

Rikin Trivedi

Cricket

Guy's 2nd XI Cricket Team Season's Report

This year must go down as one of the most successful and tiring seasons that the 2nd team has ever managed to complete. A multitude of thanks has to go to our captain, mentor and friend, Samuel Rajaratnam, for leading us through this long and, at times, strenuous season.

Moses (as we affectionately call skips) had a tough act to follow after Blunders and Anjay lead last years team to an unbeaten record spanning ten games, so I think I speak for the whole squad when saying that this year we went that little bit better - played 1, won 0, drawn 0, lost 1!

This may not seem very successful to the unknowledgeable eye of the novice cricketer, but behind this tangled web of statistics lies some great individual performances. How could one forget the 60 not out and 5 wickets by the opposition captain, the superb Tapan of The Royal Free (Surely one of the greatest sporting hospitals of modern times, not!). This talented allrounder (and Sam's best mate) took the bull by the horns with a dazzling array of strokes and some fine 'dolly drop' offspinners, which sadly killed off a spirited fight from our team which encompassed some great batting from Anjay, Sam (who saved himself for the no.11 spot) and the Lara-esque Steve 'Beano' Allen.

To bring the curtain down on a great, but perhaps, a slightly brief season may I wish next year's skipper all the best for the coming season; you certainly have a tough act to follow! One piece of advice: don't organize too many games as in these times of high pressure, professional cricket it is wise to avoid the dreaded career-threatening 'burn-out' syndrome.

PP & SD

Rifle Club

Hospitals' Cup Fullbore Rifle Competition, 14th July 1995

Bisley Week is one of the high points of the fullbore shooting calendar. The opening day's events have traditionally included the Hospitals' Cup Competition, and more recently the annual meeting of the Guy's Hospital synchronized 'juniper-pebbledashing' society in the Surrey Clubhouse's garden. However, this year, much to the groundsman's delight, Guy's Hospital had neglected to enter a team for either event. This was in contrast to the previously unheard of UMDS Rifle Club, which had entered 3 teams.

By midday everyone had arrived at Bisley Army Camp. Everyone, that is, apart from the opposition. We were now growing increasingly confident in our ability to retain the Hospitals' Cup for the third consecutive year. This was despite missing 3 team members

who had left earlier that morning aboard the 'Challa-mobile' in search of truth, justice, and some tent pegs, only to find that an A.A. mechanic and a new alternator would probably have been more useful.

The competition involved shooting targets at 300, 500, and 600 yards, the three teams from U.M.D.S. displaying the great wealth of experience and skill in the club by achieving 1st, 2nd and 3rd places! The 'C' team (comprising of John Bellringer, Doctor K. Lewis, Will Fellingham, and Sunil 'Beefeater' Nair) were overall winners, despite one member, who shall remain nameless (but he was the last one in the previous list of names) shooting the lowest score of the day and even managing to miss the target on several occasions.

It was disappointing that this year we were forced to compete amongst ourselves for the Hospitals' Cup, and unless this sudden loss of interest displayed by the other hospitals is resolved, it may become necessary to widen the eligibility criteria for entry still further - next year we could be competing against teams consisting of staff, students and patients.

Many thanks to everyone who took part: Dr. Rich, John Bellringer, Guy Palmer, Simon Smallwood, Liz Smallwood, Harry Evans, Kier Lewis, Sunil Nair, Will Fellingham, Daniel Perkin, Paul Hayden, Simon Hughes, Ben 'Billy' Challacombe.

Simon Hughes

Apology

In the October issue, a number of errors appeared in the article about John Keats entitled '*John Keats and other Doctors*'. These were due to technical difficulties with the word-processing equipment which have subsequently been rectified. We apologize to the author and our readers if this affected your enjoyment of the article.

Hallet Prize

Dr Declan Cahill, a demonstrator in the anatomy department at UMDS, has recently been awarded the Hallet Prize in his Part 1 Fellowship at the Royal College of Surgeons. He now joins a total of three people to date who have won this award from an appointment here at Guy's.

Oriental Rugs

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Diamond Wedding

On 14th December, 1935, at Dovencourt, Essex, the marriage took place between Captain R S Vine RAMC (Guy's 1927-34) and Miss F Betty Brookes (SRCN, Evelina Hospital). This Year, they are celebrating their Diamond Wedding Anniversary. Their present address is:

'Shola'
Fielden Rd
Crowborough
E. Sussex
TN6 1TR
01892 661381

Blues & Half -Blues

Several people have expressed an interest in having blues blazers made. The material require to make the traditional blues blazer is the same for both full and half-blues, but would have to be specially ordered. If enough blazers are ordered, this becomes financially viable.

There has already been significant interest from students and the blues of several sports clubs but since there is unlikely to be such a large order again, the cost of any future orders would be prohibitive. The cost for a made-to-measure blazer would be well under £200 depending on the number of orders. If you would like to order a blazer, would like further details, or would be interested in other blues apparel (ties, scarves, waistcoats, caps etc.) or in attending a blues dinner, please write to:-

TCB Webber
14 Lower Park
Putney Hill
Putney
SW15 6QY

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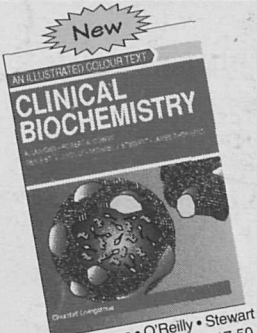

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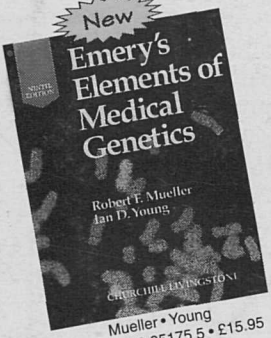

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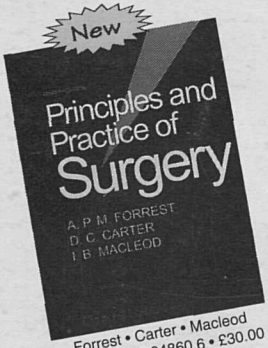

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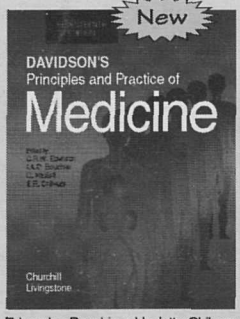

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–The Bell, April 1994

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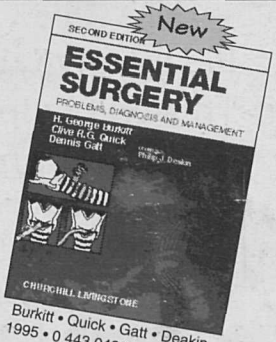

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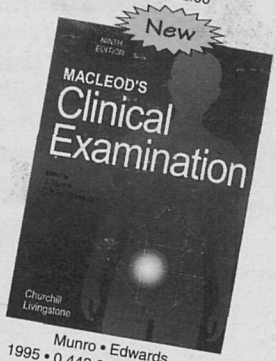

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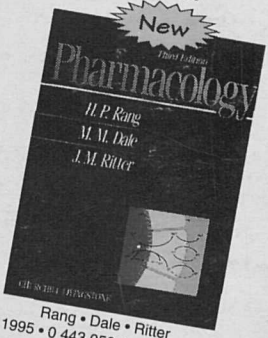

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